Application Template for Health Insurance Flexibility and Accountability (HIFA) §1115 Demonstration Proposal

The State of Washington, Department of Social and Health Services proposes a section 1115 demonstration entitled the Medicaid and State Children's Health Insurance Program (SCHIP) Reform Waiver, hereinafter referred to as MSRW, which will increase the number of individuals with health insurance coverage.

I. General Description of Program

The MSRW, which is scheduled to begin on January 1, 2003, will provide health insurance coverage to an additional 20,000 residents of the State of Washington with incomes at or below 200 percent of the Federal poverty level. These residents will be parents of Medicaid and Basic Health (BH) children and childless adults and will receive coverage through Washington State's BH program. The increased coverage will be funded by Washington's SCHIP allotment and any reallocated SCHIP funds. Beginning July 1, 2003, the MSRW will also permit changes (cost-sharing, benefit reductions and an enrollment freeze capability) in the Medicaid program to help Washington State sustain its commitment to provide subsidized health care coverage to its low-income residents, subject to prior approval and direction from the Washington State Legislature.

II. Definitions

Income: In the context of the HIFA demonstration, income limits for coverage expansions are expressed in terms of gross income, excluding sources of income that cannot be counted pursuant to other statutes (such as Agent Orange payments.)

Mandatory Populations: Refers to those eligibility groups that a State must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B. For example, States currently must cover children under age six and pregnant women up to 133 percent of poverty.

Optional Populations: Refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels. Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children covered in Medicaid above the mandatory levels, children covered under SCHIP, and parents covered under Medicaid. For purposes of the HIFA demonstrations, Section 1902(r)(2) and Section 1931 expansions constitute optional populations.

Expansion Populations: Refers to any individuals who cannot be covered in an eligibility group under Title XIX or Title XXI and who can only be covered under Medicaid or SCHIP through the section 1115 waiver authority. Examples include childless non-disabled adults under Medicaid.

Private health insurance coverage: This term refers to both group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Service Act.

III. HIFA DEMONSTRATION STANDARD FEATURES

Please place a check mark beside each feature to acknowledge agreement with the standard features.

__✔__ The HIFA demonstration will be subject to Special Terms and Conditions (STCs). The core set of STCs is included in the application package. Depending upon the design of its demonstration, additional STCs may apply.

_____ Federal financial participation (FFP) will not be claimed for any existing State-funded program. If the State is seeking to expand participation or benefits in a State-funded program, a maintenance of effort requirement will apply.

__✔__ Any eligibility expansion will be statewide, even if other features of the demonstration are being phased-in.

__✔__HIFA demonstrations will not result in changes to the rate for Federal matching payments for program expenditures. If individuals are enrolled in both Medicaid and SCHIP programs under a HIFA demonstration, the Medicaid match rate will apply to FFP for Medicaid eligibles, and the SCHIP enhanced match rate will apply to SCHIP eligibles.

__✔__ Premium collections and other offsets will be used to reduce overall program expenditures before the State claims Federal match. Federal financial payments will not be provided for expenditures financed by collections in the form of pharmacy rebates, third party liability or premium and cost sharing contributions made by or on behalf of program participants.

__✔__ The State has utilized a public process to allow beneficiaries and other interested stakeholders to comment on its proposed HIFA demonstration. A description of the public process is included in Attachment I.

IV. STATE SPECIFIC ELEMENTS

A. Upper income limit

The upper income limit for the eligibility expansion under the demonstration is 200 percent of the FPL, adjusted for actual child care costs.

If the upper income limit is above 200 percent of the FPL, the State will demonstrate that focusing resources on populations below 200 percent of the FPL is unnecessary because the State already has high coverage rates in this income range, and covering individuals above 200 percent of the FPL under the demonstration will not induce individuals with private health insurance coverage to drop their current coverage. (Please include a detailed description of your approach as Attachment A to the proposal.)

B. Eligibility

Please indicate with check marks which populations you are proposing to include in your HIFA demonstration. As described in Attachment B and other parts of this application, all mandatory and optional eligibility populations would be subject to targeted copayments. Other proposed changes under the MSRW demonstration regarding benefits, premiums, and possible enrollment freezes would affect only certain optional eligibility populations as summarized at the end of Attachment B and described in Attachments C, E, and J.

Mandatory Populations (as specified in Title XIX.)

✔ Section 1931 Families

✔ Blind and Disabled

✔ Aged

✔ Poverty-related Children and Pregnant Women

Optional Populations (included in the existing Medicaid State Plan)

Categorical

- ✔ Children and pregnant women covered in Medicaid above the mandatory level
- _____ Parents covered under Medicaid
- _____ Children covered under SCHIP
- _____ Parents covered under SCHIP
- ✔ Other (please specify) – Aged, Blind and Disabled, including workers with disabilities under Medicaid Buy-In, and uninsured women screened and diagnosed with breast and cervical cancer.

Medically Needy

__✔__ TANF Related – Children and pregnant women only.

__✔__ Blind and Disabled

__✔__ Aged

__✔__ *Title XXI children (Separate SCHIP Program)*

_____ *Title XXI parents (Separate SCHIP Program)*

Additional Optional Populations (not included in the existing Medicaid or SCHIP State Plan.) If the demonstration includes optional populations not previously included in the State Plan, the optional eligibility expansion must be statewide in order for the State to include the cost of the expansion in determining the annual budget limit for the demonstration.)

Populations that can be covered under a Medicaid or SCHIP State Plan

_____ Children above the income level specified in the State Plan
This category will include children from _____percent of the FPL through _____percent of the FPL.

_____ Pregnant women above the income level specified in the State Plan
This category will include individuals from _____percent of the FPL through _____percent of the FPL.

_____ Parents above the current level specified in the State Plan
This category will include individuals from _____percent of the FPL through _____percent of the FPL.

Existing Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, but are already receiving coverage in the State by virtue of an existing section 1115 demonstration.

_____ Childless Adults (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)

_____ Pregnant Women in SCHIP (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)

__✔__ Other. Please specify: Beginning July 2001, the Take Charge demonstration has provided family planning services only to men and women of childbearing age in families with incomes at or below 200 percent of the FPL.
(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

New Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, and will be covered only as a result of the new HIFA demonstration.

✔ Childless Adults (This category will include individuals from 0 percent of the FPL through 200 percent of the FPL.)

_____ Pregnant Women in SCHIP (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)

✔ Other. Please specify: This category will include the parents of Medicaid and Basic Health children with family income at or below 200 percent of the FPL, adjusted for actual child care costs. These individuals (and childless adults) will receive coverage through the Basic Health program, administered by the Washington State Health Care Authority.
(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

C. Enrollment/Expenditure Cap

_____ No

✔ Yes

(If Yes) Number of participants or dollar limit of demonstration

_____
The Basic Health (BH) Program expansion of coverage to parents with Medicaid and BH children and childless adults will be subject to an expenditure cap, which is the SCHIP allotment plus reallocated funds minus the amount spent on SCHIP children. New enrollment into certain current eligibility categories under Medicaid will be subject to an enrollment/ expenditure freeze described in Attachment J.

(Express dollar limit in terms of total computable program costs.)

D. Phase-in

Please indicate below whether the demonstration will be implemented at once or phased in.

_____ The HIFA demonstration will be implemented at once.

✔ The HIFA demonstration will be phased-in.

If applicable, please provide a brief description of the State's phase-in approach (including a timeline): Although implementation is planned at once, the timing for SCHIP expansion would differ from proposed Medicaid changes. The expansion activities in the Basic Health program would commence in January 2003. Changes to the Medicaid program would be proposed for July 2003, but would be implemented only with prior approval and direction from the Washington State Legislature.

E. Benefit Package

Please use check marks to indicate which benefit packages you are proposing to provide to the various populations included in your HIFA demonstration.

1. Mandatory Populations

✔ The benefit package specified in the Medicaid State Plan as of the date of the HIFA application.

2. Optional populations included in the existing Medicaid State Plan

- ✔ The same coverage provided under the State's approved Medicaid State plan, except as described in Attachment C.
- _____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
- _____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
- _____ A health benefits coverage plan that is offered and generally available to State employees
- _____ A benefit package that is actuarially equivalent to one of those listed above
- ✔ Secretary approved coverage. (The proposed benefit package is described in Attachment C for the optional adult populations to be affected. Optional children will continue to receive the same coverage provided under the state's approved Medicaid State Plan.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

3. SCHIP populations, if they are to be included in the HIFA demonstration

States with approved SCHIP plans may provide the benefit package specified in Medicaid State plan, or may choose another option specified in Title XXI. (If the State is proposing to change its existing SCHIP State Plan as part of implementing a HIFA demonstration, a corresponding plan amendment must be submitted.) SCHIP coverage will consist of:

- _____ The same coverage provided under the State's approved Medicaid State plan.
- _____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
- _____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
- _____ A health benefits coverage plan that is offered and generally available to State employees
- _____ A benefit package that is actuarially equivalent to one of those listed above
- ✔ Secretary approved coverage, as described in the state's approved SCHIP State Plan.

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

4. New optional populations to be covered as a result of the HIFA demonstration

- _____ The same coverage provided under the State's approved Medicaid State plan.
- _____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
- _____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
- _____ A health benefits coverage plan that is offered and generally available to State employees

_____ A benefit package that is actuarially equivalent to one of those listed above

_____ Secretary approved coverage. (The proposed benefit package is described in Attachment C.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

5. Expansion Populations – States have flexibility in designing the benefit package, however, the benefit package must be comprehensive enough to be consistent with the goal of increasing the number of insured persons in the State. The benefit package for this population must include a basic primary care package, which means health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. With this definition states have flexibility to tailor the individual definition to adapt to the demonstration intervention and may establish limits on the types of providers and the types of services. Please check the services to be included.

✔ Inpatient

✔ Outpatient

✔ Physician's Surgical and Medical Services

✔ Laboratory and X-ray Services

✔ Pharmacy

✔ Other (please specify) – The coverage will be the same as the Basic Health program's benefit package, including its pre-existing condition limitation, that is described in the 2002 Basic Health Member Handbook in Attachment C.

Please include a detailed description of any Secretary approved coverage or flexible expansion benefit package as Attachment C to your proposal. Please include a discussion of whether different benefit packages will be available to different expansion populations.

F. Coverage Vehicle

Please check the coverage vehicle(s) for all applicable eligibility categories in the chart below (check multiple boxes if more than one coverage vehicle will be used within a category):

Eligibility Category	**Fee-For-Service**	**Medicaid or SCHIP Managed Care**	**Private health insurance coverage**	**Group health plan coverage**	**Other (specify)**
Mandatory	✔	✔	✔(See Attachment D)	✔(See Attachment D)	
Optional – Existing	✔	✔	✔(See Attachment D)	✔(See Attachment D)	
Optional – Expansion					
Title XXI – Medicaid Expansion					
Title XXI – Separate SCHIP	✔	✔			
Existing section 1115 expansion	✔				
New HIFA Expansion					✔ - Managed Care through Basic Health

Please include a detailed description of any private health insurance coverage options as Attachment D to your proposal.

G. Private health insurance coverage options

Coordination with private health insurance coverage is an important feature of a HIFA demonstration. One way to achieve this goal is by providing premium assistance or "buying into" employer-sponsored insurance policies. Description of additional activities may be provided in Attachment D to the State's application for a HIFA demonstration. If the State is employing premium assistance, please use the section below to provide details.

As described in Attachment D, Washington State will evaluate the feasibility of a pilot program for employer-sponsored insurance coverage. The state will report its findings and conclusions to CMS.

____ As part of the demonstration the State will be providing premium assistance for private health insurance coverage under the demonstration. Provide the information below for the relevant demonstration population(s):

The State elects to provide the following coverage in its premium assistance program: (Check all applicable, and describe benefits and wraparound arrangements, if applicable, in Attachment D to the proposal if necessary. If the State is offering different arrangements to different populations, please explain in Attachment D.)

____ The same coverage provided under the State's approved Medicaid plan.

____ The same coverage provided under the State's approved SCHIP plan.

____ The benefit package for the health insurance plan that is offered by an HMO, and has the largest commercial, non-Medicaid enrollment in the State.

____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

____ A health benefits coverage plan that is offered and generally available to State employees.

____ A benefit package that is actuarially equivalent to one of those listed above (please specify).

____ Secretary-Approved coverage.

____ Other coverage defined by the State. (A copy of the benefits description must be included in Attachment D.)

____ The State assures that it will monitor aggregate costs for enrollees in the premium assistance program for private health insurance coverage to ensure that costs are not significantly higher than costs would be for coverage in the direct coverage program. (A description of the Monitoring Plan will be included in Attachment D.)

____ The State assures that it will monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make modifications in its premium assistance program. (Description will be included as part of the Monitoring Plan.)

H. Cost Sharing

Please check the cost sharing rules for all applicable eligibility categories in the chart below:

Eligibility Category	Nominal Amounts Per Regulation	Up to 5 Percent of Family Income	State Defined
Mandatory	✔(See Attachment E – reasonable copayments)		
Optional – Existing (Children)		✔(See Attachment E)	
Optional – Existing (Adults)		✔(See Attachment E)	
Optional – Expansion (Children)			
Optional _ Expansion (Adults)			
Title XXI – Medicaid Expansion			
Title XXI – Separate SCHIP		✔(See Attachment E)	
Existing section 1115 Expansion			
New HIFA Expansion			✔(See Attachment E)

Cost-sharing for children
Only those cost-sharing amounts that can be attributed directly to the child (i.e. co-payments for the child's physician visits or prescription drugs) must be counted against the cap of up to five percent of family income. Cost-sharing amounts that are assessed to a family group that includes adults, such as family premiums, do not need to be counted as 'child cost-sharing' for the purposes of the up to five percent cost-sharing limit. A premium covering only the children in a family must be counted against the cap.

Below, please provide a brief description of the methodology that will be used to monitor child-only cost-sharing expenses when the child is covered as part of the entire family and how those expenses will be limited to up to five percent of the family's income.

Any State defined cost sharing must be described in Attachment E. In addition, if cost sharing limits will differ for participants in a premium assistance program or other private health insurance coverage option, the limits must be specified in detail in Attachment E to your proposal.

V. Accountability and Monitoring

Please provide information on the following areas:

1. Insurance Coverage

The rate of uninsurance in your State as of 2000 for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project is presented in the following table derived from the 2000 Washington State Population Survey (WSPS):

WASHINGTON STATE		
	Estimate Number	Percentage
State Pop.: Total	5,894, 121	100%
State Pop: ≤ 200 % FPL:	1,704,600	29%
Of State Pop. ≤ 200 % FPL:		
Uninsured	308,100	18%
With group coverage	*599,100	35%
With Individual coverage	72,000	4%
With Medicaid	519,000	30%
With Medicare	194,410	**
With other Insurance: Basic Health Plan	125,000	7%

* Includes self-funded ERISA and Taft-Hartley Trust plans

** A 2002 DSHS estimate identified over 60 percent of this population as dual Medicare-Medicaid clients.

Washington's SCHIP was created in 1999 for children between 200 percent and 250 percent of FPL. Premiums are set at $10 per child, per month for a maximum of three. Enrollment began in February 2000 and at the end of that calendar year enrollment was 3,520. As of May 2002, there were 6,798 children enrolled in SCHIP.

The coverage rates in your State for the insurance categories for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project: See table above.

Private Health Insurance Coverage Under a Group Health Plan

_____

Other Private Health Insurance Coverage _____

Medicaid (please separately identify enrollment in any section 1906 or section 1115 premium assistance)

_____

_____

SCHIP (please separately identify any premium assistance)

_____

Medicare _____

Other Insurance _____

Indicate the data source used to collect the insurance information presented above (the State may use different data sources for different categories of coverage, as appropriate):

_____ The Current Population Survey

_____ Other National Survey (please specify_____)

__✔__ State Survey (please specify_WSPS_)

_____ Administrative records (please specify_____)

_____ Other (please specify_____)

Adjustments were made to the Current Population Survey or another national survey.

_____ Yes __✔__ No

If yes, a description of the adjustments must be included in Attachment F.

A State survey was used.

__✔__ Yes _____ No

If yes, provide further details regarding the sample size of the survey and other important design features in Attachment F.

If a State survey is used, it must continue to be administered through the life of the demonstration so that the State will be able to evaluate the impact of the demonstration on coverage using comparable data.

2. State Coverage Goals and State Progress Reports

The goal of the HIFA demonstration is to reduce the uninsured rate. For example, if a State was providing Medicaid coverage to families, a coverage goal could be that the State expects the uninsured rate for families to decrease by 5 percent. Please specify the State's goal for reducing the uninsured rate:

The goal of Washington State's MSRW demonstration project is to sustain the state's current Medicaid coverage commitments and expand Basic Health program enrollment by 20,000 adults.

Attachment F must include the State's Plan to track changes in the uninsured rate and trends in sources of insurance as listed above. States should monitor whether there are unintended consequences of the demonstration such as high levels of substitution of private coverage and major decreases in employer contribution levels. (See the attached Special Terms and Conditions.)

__✔__ Annual progress reports will be submitted to CMS six months after the end of each demonstration year which provide the information described in this plan for monitoring the uninsured rate and trends in sources of insurance coverage.

States are encouraged to develop performance measures related to issues such as access to care, quality of services provided, preventative care, and enrollee satisfaction. The performance plan must be provided in Attachment F.

VI. PROGRAM COSTS

A requirement of HIFA demonstrations is that they not result in an increase in federal costs compared to costs in the absence of the demonstration. Please submit expenditure data as Attachment G to your proposal. For your convenience, a sample worksheet for submission of base year data is included as part of the application packet.

The base year will be trended forward according to one of the growth rates specified below. Please designate the preferred option:

_____ Medical Care Consumer Price Index, published by the Bureau of Labor Statistics. (Available at http://stats.bls.gov.) The Medical Care Consumer Price Index will only be offered to States proposing statewide demonstrations under the HIFA initiative. If the State chooses this option, it will not need to submit detailed historical data.

_____ Medicaid-specific growth rate. States choosing this option should submit five years of historical data for the eligibility groups included in the demonstration proposal for assessment by CMS staff, with quantified explanations of trend anomalies. A sample

worksheet for submission of this information is included with this application package. The policy for trend rates in HIFA demonstrations is that trend rates are the lower of State specific history or the President's Budget Medicaid baseline for the eligibility groups covered by a State's proposal. This option will lengthen the review time for a State's HIFA proposal because of the data generation and assessment required to establish a State specific trend factor.

The State estimates the cost of this program will be $_____ over its _____ year approval period.

Title XIX Budget Neutrality

The Department of Social and Health Services (DSHS) makes assurances that its MSRW demonstration waiver comports with the HIFA requirement that the demonstration waiver will not result in an increase in federal costs compared to costs in the absence of the demonstration. These assurances can be made because Washington's demonstration would not cover services that are not otherwise allowed and matchable under Title XIX. The demonstration also would not cover eligibility groups that are not otherwise allowed and matchable under Title XIX.

Moreover, the programmatic changes requested in the waiver would reduce the costs that the federal and state governments would otherwise incur without the demonstration. The adoption of cost-sharing (copayments and premiums) and benefit design reductions would reduce the per-capita costs for eligibility groups covered under the demonstration below what would be expected without the demonstration. If an enrollment freeze needs to be implemented during the demonstration period, the enrollment limits for Medicaid optional coverage groups covered under the demonstration would reduce the caseload and expenditures below what would be expected without the demonstration.

DSHS has made preliminary estimates of anticipated savings from adopting premiums and benefit design changes for state fiscal years (SFY) 2004 and 2005. It is estimated that the payment of premiums will reduce total expenditures by $25 million per year below what would otherwise occur without the demonstration and the reduction in benefits for certain optional adults will reduce expenditures by $2 million per year. See Attachment G for calculation of these estimates.

DSHS' consulting actuaries have conducted a preliminary analysis, which confirms the application of the targeted brand-name and emergency room copayments will reduce inappropriate utilization. However, given the need to selectively implement the brand-name copayments in a changing environment and the implementation of a nurse consulting service, DSHS is not projecting a specific saving amount at this time.

Title XXI Allotment Neutrality

DSHS assures that Title XXI FFP for its SCHIP children's program and the coverage for parents of Medicaid and BH children, and childless adults through the BH program, will not be greater than the state's cumulative allotment and any reallocated SCHIP funds.

Attachment G includes projections and BH coverage financed by the state's Health Services Account (HSA) and Title XXI matching funds. These estimates demonstrate that Washington would be able to finance its SCHIP plus additional BH capacity within its projected annual Title XXI allotment.

VII. WAIVERS AND EXPENDITURE AUTHORITY REQUESTED

A. Waivers

The following waivers are requested pursuant to the authority of section 1115(a)(1) of the Social Security Act (Please check all applicable):

Title XIX:

_____ **Statewideness 1902(a)(1)**

To enable the State to phase in the operation of the demonstration.

__✔__ **Amount, Duration, and Scope 1902(a)(10)(B)**

To permit the provision of different benefit packages to different populations in the demonstration. Benefits (i.e., amount, duration and scope) may vary by individual based on eligibility category.

_____ **Freedom of Choice 1902(a)(23)**
To enable the State to restrict the choice of provider.

Title XXI:

__✔__ **Benefit Package Requirements 2103**

To permit the State to offer a benefit package that does not meet the requirements of section 2103 and retain pre-existing condition limitations under the Basic Health program.

_____ **Cost Sharing Requirements 2103(e)**

To permit the State to impose cost sharing in excess of statutory limits.

B. Expenditure Authority

Expenditure authority is requested under Section 1115(a)(2) of the Social Security Act to allow the following expenditures (which are not otherwise included as expenditures under Section 1903 or Section 2105) to be regarded as expenditures under the State's Title XIX or Title XXI plan.

Note: Checking the appropriate box(es) will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.

_____ Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.

Expenditures related to providing _____ months of guaranteed eligibility to demonstration participants.

__✔__ Expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply.

Title XXI:

__✔__ Expenditures to provide services to populations not otherwise eligible under a State child health plan.

_____ Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not for targeted low-income children.

If additional waivers or expenditure authority are desired, please include a detailed request and justification as Attachment H to the proposal.

VIII. ATTACHMENTS

Place check marks beside the attachments you are including with your application.

_____ Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage.

__✔__ Attachment B: Detailed description of expansion populations included in the demonstration.

__✔__ Attachment C: Benefit package description.

__✔__ Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.

__✔__ Attachment E: Detailed discussion of cost sharing limits.

__✔__ Attachment F: Additional detail regarding measuring progress toward reducing the rate of uninsurance.

__✔__ Attachment G: Budget worksheets.

__✔__ Attachment H: Additional waivers or expenditure authority request and justification.

__✔__ Attachment I: Public Process

__✔__ Attachment J: Enrollment/Expenditure Freeze

IX. SIGNATURE

_____ _____

Date Name of Authorizing State Official (Typed)

_____

Signature of Authorizing State Official

DRAFT

ATTACHMENTS
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ATTACHMENT B
Demonstration Populations

I. MEDICAID - The following information summarizes the current mandatory and optional categories of eligibility under the Washington State Medicaid State Plan. The income limits below are the standards currently in effect. A summary of persons eligible by Medicaid and SCHIP eligibility groups during May 2002 is included with this attachment. It also identifies the groups affected by the proposed Medicaid changes.

As described in Attachment E, targeted copayments would affect all Medicaid eligibility categories, and proposed premiums would affect certain optional Medicaid clients with income above the Federal Poverty Level (FPL). (Both types of cost-sharing would also apply to children under the State Children's Health Insurance Program [SCHIP] described in Section II below.) Attachment C includes a description of the proposed benefit design change under Medicaid that would apply only to adults in certain optional eligibility groups. (It also describes the Basic Health (BH) program benefit package proposed for the expansion population described in Section III below.) Attachment J describes the optional populations that would be affected by an enrollment freeze.

FAMILY MEDICAL

TANF (TEMPORARY ASSISTANCE FOR NEEDY FAMILIES) and FAMILY MEDICAL PROGRAM: This mandatory Categorically Needy (CN) program provides aid to children and adult(s) who care for them. Families with dependent children under the age of 19, whose income and resources are below TANF limits may receive both TANF cash benefits and CN medical. TANF cash benefits are restricted to 60 months maximum in a lifetime, but there is no time limit for receiving medical.

INCOME LIMITS – FAMILIES WITH DEPENDENT CHILDREN

NUMBER OF PERSONS	CN INCOME LIMIT
1	$349
2	$440
3	$546
4	$642
5	$740
6	$841

In determining net income, deductions are allowed for 50 percent of the family's earnings, actual childcare costs, and child support paid out by the family. For medical eligibility, a family may have $1,000 in resources at the time of application. Once a family is eligible, there is no resource test for families who receive only medical.

MEDICAL EXTENDED BENEFITS (MEB): This mandatory CN program provides families up to 12 months of extended CN medical benefits when earned income increases above program standards. These benefits are sometimes called Transitional Medical Assistance (TMA). Beginning July 2002, a premium is charged to all nonpregnant adults during the second six months of MEB, if the family's countable income is over 100 percent of the Federal Poverty Level (FPL). Families are eligible for up to 4 months of extended CN medical benefits when increased child support received as countable income exceeds the TANF income limit.

WOMEN'S HEALTH

PREGNANCY: The mandatory CN medical program for low-income pregnant women has no resource limits and the income limits are based on 185 percent of the FPL. (TANF cash benefits are also available to lower-income pregnant women.) States are required to offer coverage to pregnant women and infants with incomes up to 133 percent of FPL. At their option, Washington and other states have been able to offer coverage up to 185 percent of FPL. Washington began offering coverage up to 185 percent of FPL in 1989 as part of its First Steps initiative to improve children's health. Under federal law, once coverage is offered at the higher income level, it becomes a mandatory coverage requirement. Pregnant women with income above 185 percent FPL may be eligible for the Medically Needy program.

The pregnant woman can be eligible at any time during her pregnancy. Once eligible, the woman continues to be eligible throughout the pregnancy and postpartum period regardless of changes in income and household composition. Continued medical coverage is provided for 60 days after the month in which pregnancy ends (e.g., pregnancy ends June 10, medical benefits continue through August 31). The woman receives this extension regardless of how the pregnancy ends.

To determine the pregnant woman's family size, count the pregnant woman and add one for each verified unborn. For example, a woman who verifies she is pregnant with twins is considered to be a three-person family.

NUMBER OF PERSONS	INCOME LIMIT – 185% FPL
1	NA
2	$1,841
3	$2,316
4	$2,791
5	$3,266
6	$3,741
Add $475 for each additional household member	

BREAST AND CERVICAL CANCER Treatment Coverage: This optional CN program began in July 2001 and provides medical coverage for women who have been diagnosed with breast or cervical cancer or a related pre-cancerous condition. To be eligible, a woman must be

identified as needing treatment through the Department of Health's (DOH) Breast and Cervical Health Program (BCHP) or by the Breast and Cervical Early Detection program funded by the Centers for Disease Control. Income eligibility is at or below 200 percent of FPL for the DOH screening program.

An uninsured woman is eligible if she:

- Is under age 65;
- Has been screened by the BCHP and the CDC-funded program;
- Requires treatment for breast or cervical cancer; and
- Does not have other insurance.

FAMILY PLANNING: A new family planning program began in July 2001 called Take Charge. This program operates under an existing 1115 demonstration and covers pre-pregnancy family planning services, helping participants take charge of their lives before an unintended pregnancy occurs. It expands on an earlier state initiative that provides to women family planning services only for an additional ten months following their 60-day postpartum period.

Under Take Charge, both women and men may be eligible if:

- Their family income is at or below 200 percent of FPL;
- They do not have health insurance coverage; or
- Their current health insurance coverage does not include comprehensive family planning benefits.

NUMBER OF PERSONS	INCOME LIMIT – 200% FPL
1	$1,477
2	$1,990
3	$2,504
4	$3,017
Add $514 for each additional household member	

CHILDREN'S MEDICAL

The CN medical program for children has both mandatory and optional components. Washington's mandatory eligibility group coverage includes: infants up to age 1 in households up to 185 percent of FPL; children age one through five up to 133 percent of FPL; and children age six through 18 up to 100 percent of FPL. Children receiving adoption support or foster maintenance payments under Title IV-E also receive mandatory CN coverage regardless of income. Other children under age 19 in households with income up to 200 percent of FPL are optional CN.

NEWBORNS: Newborns are automatically eligible for mandatory CN coverage for 12 months if their mother received medical benefits at the time of the child's birth. There are no additional income or resource limits.

CHILDREN UNDER AGE 19: This CN program has no resource limits and the income limits are based on 200 percent of the FPL. Living with a parent/guardian is not a requirement for eligibility in this program. Children remain eligible for 12 months regardless of changes of circumstances.

NUMBER OF PERSONS	INCOME LIMIT – 200% FPL
1	$1,477
2	$1,990
3	$2,504
4	$3,017
5	$3,530
6	$4,044
Add $514 for each additional household member	

In determining the net income, the family can deduct a $90 earned income disregard for each working parent, actual childcare costs, and child support paid out by the family.

AGED, BLIND, AND DISABLED SSI-RELATED MEDICAL COVERAGE

SSI (SUPPLEMENTAL SECURITY INCOME) & SSI-RELATED: Aged, blind, or disabled persons with income and resources below federal SSI limits may receive both SSI cash benefits and Categorically Needy (CN) medical, or they may receive CN medical only. Persons receiving SSI cash benefits are in mandatory CN programs. Other SSI-related persons are in optional CN programs or in the Medically Needy program. Income and resource standards are the same for CN medical only as for SSI cash benefits.

A different income standard is used to determine eligibility for optional CN coverage to aged, blind and disabled persons who need "institutional level care" (e.g., hospital, nursing facility or ICF-MR services) and the associated long-term care services. The standard is 300 percent of the Federal Benefit Rate (FBR) and is called the Special Income Level (SIL). If gross income is at or below the SIL, optional CN eligibility for either institutional or home and community-based waivered service programs may be approved with clients participating toward the cost of care. Persons with income and/or resources above SSI or SIL limits may be eligible for the Medically Needy program.

The SSI income standard is the Federal Benefit Rate (FBR). Washington State historically provided State-funded Supplemental Payments (SSP) to eligible SSI clients in addition to the FBR they receive from the federal Social Security Administration. SSP differed based on the client's living situation and the area of the state where the client lives. With the July 2002 elimination of SSP in Washington State, the Area 1 and Area 2 income limits will remain fixed until the FBR exceeds the current amounts.

- Area 1 includes King, Pierce, Snohomish, Thurston, and Kitsap counties.
- Area 2 includes all other counties in the state.

Income standards in the table below are the total of the FBR plus the former SSP.

NUMBER OF PERSONS	ABD RESOURCE LIMIT	ABD INCOME LIMIT AREA 1	ABD INCOME LIMIT AREA 2
1	$2,000	$570.90	$550.45
2	$3,000	$836.90	$817.00

HEALTHCARE FOR WORKERS WITH DISABILITIES (HWD): HWD is an optional CN medical program that recognizes the employment potential of people with disabilities. Under HWD, workers with disabilities (age 16 through 64) can earn more money and purchase healthcare coverage for an amount based on a sliding income scale.

HWD has no asset test and the income limits are based on 220 percent of FPL.

NUMBER OF PERSONS	INCOME LIMIT – 220% FPL
1	$1,575
2	$2129

To be eligible, a person must meet federal disability requirements, be employed (including self-employment) full or part time and pay a monthly premium based on the following formula.

Cost of enrollment:
To receive HWD benefits, enrollees pay a monthly premium equal to:

- Fifty percent of any unearned income in excess of the medically needy income level (MNIL) - the current MNIL is $571; and
- Five percent of all unearned income; and
- Two and a half percent of earned income after deducting $65.

MEDICARE SAVINGS PROGRAM

There are five different Medicare cost sharing programs that are mandatory CN under Medicaid. Under these programs, DSHS must pay certain Medicare-related charges for eligible aged, blind, and disabled clients. These programs have higher income and resource limits.

QUALIFIED MEDICARE BENEFICIARY (QMB): The client must be entitled to Medicare Part A. Income limits are based on 100 percent of the Federal Poverty Level (FPL). Under QMB, DSHS pays for Medicare Part B premiums, deductibles, copayments, and any Medicare Part C, that covers HMO premiums and copayments.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB): The client must have applied for or be enrolled in Medicare Part A. Income limits are over 100 percent of the Federal

Poverty Level (FPL) but under 120 percent of the FPL. Under SLMB, DSHS pays the client's Medicare Part B premium **only**.

QUALIFIED Individual (QI-1) (formerly ESLMB**):** The client must have applied for or be enrolled in Medicare Part B and not be eligible for any other Medicaid coverage. Income limits are from 120 percent of the Federal Poverty Level (FPL) to 135 percent of the FPL. Under QI-1, DSHS pays the client's Medicare Part B premium **only**.

QUALIFIED INDIVIDUAL (QI-2): The client must have applied for or be enrolled in Medicare Part A and not be eligible for any other Medicaid coverage. Income limits are from 135 percent of the Federal Poverty Level (FPL) to 175 percent FPL. Clients who are eligible for QI-2 receive help with the cost of their Medicare premium in the form of a cash payment (currently $3.91 per month) which is paid annually. Federal funding for QI-2 is limited.

QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI): The client must have applied for or be enrolled in Medicare Part A as a working disabled person who has exhausted premium-free Part A and whose SSA disability benefits ended because the client's earnings exceeded SSA's gainful activity limits. Income limits are based on 200 percent of the Federal Poverty Level (FPL). DSHS pays the client's Medicare Part A premium **only**.

COST SHARING PROGRAM	FEDERAL POVERTY LEVEL	ONE PERSON	TWO PERSONS
QMB	100%	$ 739	$ 995
SLMB	120%	$ 886	$1,194
QI-1	135%	$ 997	$1,344
QI-2	175%	$1,293	$1,742
QDWI	200%	$1,477	$1,990
Resource Limit		$4,000	$6,000

REFUGEES AND ALIENS

REFUGEES: The Refugee Program is a 100 percent federally funded program for certain persons after entering the United States. A person who has been granted asylum in the U.S. or admitted as a refugee, and who is not otherwise eligible for the Family Medical or SSI programs, may receive cash and medical benefits for a maximum of eight months. These persons are generally single individuals or couples without children, and they receive CN scope of medical services.

Refugees/asylees who have income above cash grant limits may be eligible for the Medically Needy program for a maximum of eight months from date of entry in the country (if a refugee) or the date that asylum is granted (if an asylee), when they spend down excess income. Refugees who have been in the U.S. for more than eight months, and asylees whose date asylum was granted is more than eight months earlier, are eligible for medical benefits the same as U.S. citizens.

ALIEN EMERGENCY MEDICAL (AEM): AEM is a mandatory CN program for noncitizen aliens with emergent medical conditions, including labor and delivery. The person must be categorically related to a Medicaid program (e.g., a parent with a dependent child, a disabled adult or a child under age 19), but be ineligible for Medicaid due to citizenship or alien status. Persons eligible for AEM can receive medical benefits for the emergent condition only. Income and resource limits are the same as for the program to which they are related, i.e., CN or MN.

MEDICALLY NEEDY

MEDICALLY NEEDY: The Medically Needy (MN) program is an optional Medicaid program for aged, blind, or disabled persons, pregnant women, children and refugees with income and/or resources above CN limits. It provides slightly less medical coverage than CN and requires greater financial participation by the client.

Medically Needy (MN) clients with income above MN limits are required to spend down excess income before medical benefits can be authorized. Twenty dollars of the client's income is disregarded when determining income limits. The amount of the client's spenddown is computed using a base period, consisting of three or six consecutive calendar months. The client spends down the excess by incurring medical bills equal to the spenddown amount. The client is responsible for paying these medical bills.

NUMBER OF PERSONS	MN RESOURCE LIMIT	MN INCOME LIMIT
1	$2,000	$ 571
2	$3,000	$ 592
3	$3,050	$ 667
4	$3,100	$ 742
5	$3,150	$ 858
6	$3,200	$ 975
7	$3,250	$1,125
8	$3.300	$1,242
9	$3,350	$1,358
10	$3,400	$1,483
+10	+$50/Person	Maximum $1,483

II. SCHIP - The following information describes the coverage in Washington State under Title XXI for the State Children's Health Insurance Program (SCHIP), a nonentitlement "Medicaid look-alike" program.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP): SCHIP is an optional program that covers children under age 19 in families whose income is too high for Medicaid, but below 250 percent of FPL. To be eligible for SCHIP a child:

1. Cannot be eligible for Medicaid;
2. Cannot be covered by other creditable insurance; and
3. Must pay monthly premiums to the department.

NUMBER OF PERSONS	INCOME LIMIT – 200%-250% FPL
1	$1,846
2	$2,488
3	$3,130
4	$3,771
5	$4,413
6	$5,055
Add $642 for each additional household member	

Children with income above 250 percent of FPL may be eligible for the Medically Needy program.

III. New Expansion - The following information describes the expanded coverage proposed in Washington State under the MSRW demonstration project.

Washington State would provide expanded coverage through the Basic Health (BH) program, administered by the Washington State Health Care Authority, to parents of Medicaid and BH children and childless adults with family income at or below 200 percent of FPL, adjusted for actual childcare costs. As described in Attachment C, these adults would have the same benefit coverage as other BH enrollees, including pre-existing condition limitations under the BH program. Cost-sharing requirements would also be the same as for other BH enrollees as described in the BH Member Handbook included with Attachment C. This expansion would be funded by unspent SCHIP allotments (and any reallocated funds) available to Washington State.

State of Washington
Department of Social and Health Services
Amended Medicaid & SCHIP Reform Waiver Application
July 22, 2002

MEDICAID & SCHIP REFORM WAIVER - WAIVER STATUS

Categories	January 2002 Eligibles				Waiver Provisions			
	Adults	Children [1]	Total	Percent of Total [2]	Copayments	Premiums	Benefit [3]	Enrollment Freeze
Non-Waiver Demonstration Groups								
CN Family Medical	94,659	176,486	271,145	32.6%	X	TMA Revised	Medicaid	
CN Aged	55,455		55,455	6.7%	X		Medicaid	
CN Blind & Disabled	101,187	15,138	116,325	14.0%	X		Medicaid	
CN Optional Breast and Cervical Cancer	91		91	0.0%	X		Medicaid	
CN Pregnant Women	22,488	1,596	24,084	2.9%	X		Medicaid	
CN Mandatory Children		174,176	174,176	20.9%	X		Medicaid	
CN Foster Care & Adoption Support		15,648	15,648	1.9%	X		Medicaid	
CN Family Planning	67,688	13,276	80,964	9.7%	X		FP only	
SLMB Cost-Sharing Only	6,001		6,001	0.7%	X		Medicaid	
Refugee	780	40	820	0.1%	X		Medicaid	
Total	348,349	396,360	744,709	89.5%				
Total less Family Planning	280,661	383,084	663,745	79.7%				
Waiver Demonstration Groups								
CN Optional Children		147,667	147,667	17.7%	X	X	Medicaid	X
CN Optional HWD	50		50	0.0%	X	HWD Revised	Waiver	X
MN Aged	5,839		5,839	0.7%	X	X	Waiver	X
MN Blind & Disabled	8,319	1	8,320	1.0%	X	X	Waiver	X
MN Other	20	34	54	0.0%	X	X	Waiver	X
SCHIP		6,798	6,798	0.8%	X	SCHIP Revised	Medicaid	X
Total	14,228	154,500	168,728	20.3%				
Total Medicaid 2	362,577	550,860	913,437	109.7%				
Total Medicaid Less Family Planning	294,889	537,584	832,473	100.0%				

NOTES:

[1] Children are persons under age 19.

[2] Percentage is total Medicaid enrollees less family planning enrollees.

[3] Medicaid coverage is the same benefit package received prior to the waiver. Waiver benefit design would be the Medicaid benefit design minus nonemergent dental, vision care and hearing care.

DRAFT

ATTACHMENT C
Benefit Package Description

Washington State's Medicaid and SCHIP Reform Waiver (MSRW) demonstration project would retain the benefit package specified in the Medicaid and SCHIP State Plans for all children. It would retain the Medicaid benefit design for most adults and reduce the Medicaid benefit design for certain optional adults identified below. Long-term care services (such as nursing facility and ICF/MR services, personal care, adult day health, and home and community-based services), mental health services, alcohol/substance abuse services, and family planning services would not be affected under the proposed MSRW changes.

The benefit design reduction for certain adults would include:

(1) Nonemergent dental care, including dentures. Emergent dental care performed by a physician, or medical and surgical services furnished by a dentist to the extent such services can be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine are mandatory coverage requirements and would continue to be covered;

(2) Routine optical care including eye glasses, contacts or other vision aids; and,

(3) Routine hearing care, including hearing aids.

Washington State would retain flexibility under current federal law to change optional services for mandatory and optional populations as permitted under the Medicaid State Plan.

The following paragraphs provide more details about which populations would be affected by the MSRW benefit design reduction:

1. Mandatory Populations

Mandatory populations will continue to receive full-scope Medicaid coverage as defined in the state's Medicaid State Plan. Mandatory populations include those in the following programs: Categorically Needy (CN) Family Medical; CN Aged; CN Blind & Disabled; CN Pregnant Women; CN Children; CN Foster Care & Adoption Support; Medicare Cost-Sharing Only; and Refugees.

2. Optional Populations included in the existing Medicaid and SCHIP State Plans

A. Optional children will continue to receive full scope Medicaid benefits as offered to mandatory CN children. Optional children include: Medicaid children above the mandatory FPL and up to 200 percent of FPL; and SCHIP children between 200 percent to 250 percent of FPL.

B. Optional lower income adults receiving CN benefits will continue to receive full scope CN benefits. These populations include: optional CN Aged; optional CN Blind & Disabled; and optional CN Breast and Cervical Cancer women.

C. Certain optional higher income adults would be subject to the reduced benefit design. These optional adults include those in the following programs: optional CN Healthcare for Workers with Disabilities; Medically Needy (MN) Aged; MN Blind & Disabled; and MN other.

3. Expansion Populations

Through the Basic Health (BH) program, Washington State would expand coverage to parents of Medicaid and BH children and childless adults with family income at or below 200 percent of FPL. This expansion population would be subject to the BH pre-existing conditions criteria.

The following page provides an overview of services covered within each of the benefit designs (Categorically Needy, Medically Needy, the MSRW, and the BH program.) A more detailed description of the benefit package under the BH program is included in Chapter 4 of the enclosed 2002 BH Member Handbook. An actuarial report from Milliman USA, Inc., is also enclosed to demonstrate that the BH benefit package meets the requirements of benchmark equivalent coverage under the requirements of section 2103 and exceeds the benefit package requirement for expansion populations.

MEDICAID & BASIC HEALTH PROGRAMS' BENEFIT DESIGN COMPARISON

(X = Covered Service; L = Limited Coverage; EPSDT = Early and Periodic, Screening Diagnosis and Treatment)

Services	CN/SCHIP	MN	MSRW	BH	Comments
Adult Day Health	X		X		
Advanced RN Practitioner Services	X	X	X	L	Under BH, covered at the discretion of Health Plans
Ambulance/Ground and Air	X	X	X	X	
Anesthesia Services	X	X	X	X	
Audiology	X	EPSDT	EPSDT		
Blood/Blood Administration	X	X	X	X	
Case Management - Maternity	L	L	L		
Chiropractic Care	EPSDT	EPSDT	EPSDT	L	BH covers service for a maximum of 6 visits annually; must be tied to surgery.
Dental Services	X	X	L		Limited to emergency dental services
Dentures Only	X	X			
Detox Alcohol (3 days)	X	X	X	X	
Drugs and supplies, prescription	X	X	X	X	
Elective Surgery	X	X	X		
Emergency Room Services	X	X	X	X	
Emergency Surgery	X	X	X	X	
Eyeglasses and Exams	X	X			
Family Planning Services	X	X	X	X	
Healthy Kids (EPSDT)	X	X	X		
Hearing Aid	X	EPSDT	EPSDT		
Home Health Services	X	L	L	X	
Hospice	X	X	X	X	
Inpatient Hospital Care	X	X	X	X	
Interpreter Services	X	X	X	X	
Maternity Support Services	X	X	X		
Medical Equipment	X	X	X	L	BH will cover DME based on cost/benefit analysis.
Neurodevelopmental Centers	X	X	X		
Nursing Facility Services	X	X	X	L	CN and MN provide both short and long-term nursing facility services. BH will cover only as an alternative to hospitalization in an acute care facility.
Nutrition Therapy	EPSDT	EPSDT	EPSDT	L	Under BH, covered at the discretion of Health Plans
Optometry	X	X	EPSDT		
Organ Transplants	X	X	X	L	BH covers - must be enrollee for 12 consecutive months before service is covered, unless newborn, or if condition is contracted while enrolled in BH.
Orthodontia	L				
Outpatient Hospital Care	X	X	X	X	
Oxygen/Respiratory Therapy	X	X	X	X	
Pain Management (chronic)	X	X	X	X	BH - may be covered by Health Plan as cost containment mechanism.
Personal Care Services	L	EPSDT	EPSDT		CN - Long-term care services.
Physical/Occupational/Speech Therapy	X	EPSDT/L	EPSDT/L	L	MN - Covered under Healthy Kids; and Covered when client is receiving home health services. BH covers physical therapy for a maximum of 6 visits annually-must be tied to surgery.
Physical Medicine and Rehab	X	X	X		
Physician Services	X	X	X	X	
Podiatry Services	X	X	X		
Private Duty Nursing	L	L	L	L	Under BH, covered at the discretion of Health Plans
Prosthetic Devices & Mobility Aids	X	X	X	L	BH will cover based on cost/benefit analysis.
Inpatient Mental Health	X	X	X	X	BH covers up to 10 days inpatient days; MAA does not have inpatient limits.
Outpatient Mental Health	X	X	X	X	BH covers 12 visits per calendar year. All Medicaid clients have up to 12 visits per calendar year. In addition Medicaid clients have access the mental health services provided by RSNs.
School Medical Services	X	X	X		
Substance Abuse/Outpatient (Detox Drugs)	X	X	X	X	BH covers up to $5,000 in a 24 consecutive month period or a $10,000 lifetime maximum; MAA covers up to 5 days for Detox Substance Abuse.
Total Enteral/Parenteral Nutrition	X	X	X	L	Under BH, covered at the discretion of Health Plans
Transportation Other Than Ambulance	X	X	X		
X-ray and Lab Services	X	X	X	X	

1) Following are additional places of service that render care to Medicaid beneficiaries: community mental health centers; Indian Health Clinics; and Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC).

2) Involuntary Commitment is a mental health service available to all residents of the state regardless of income.

3) Additional Mental Health Benefits are offered through the Regional Support Networks. They include: Emergency crisis intervention services; Case management services; Psychiatric treatment including medication supervision; and Counseling and psychotherapy services.

2002

Basic Health Member Handbook

HCA 22-405 (1/02)

Health Plan Phone Numbers and Web Sites

	Customer Service Hours:	Customer Service Phone Numbers:	Web Site Address:
Aetna U.S. Healthcare of Washington, Inc.	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-654-6506 or 206-701-1100 TTY: 1-877-580-5017	aetnaushc.com
Columbia United Providers, Inc.	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-315-7862 or 360-891-1520 TDD: 1-866-287-9962	Pending at time of publication
Community Health Plan of Washington	Mon. – Fri. 8 a.m. – 6 p.m.	1-800-440-1561 or 206-521-8830 TTY: 1-800-833-6388	www.chpw.org
Group Health Cooperative of Puget Sound	Mon. – Fri. 7:30 a.m. – 6 p.m.	1-888-901-4636	www.ghc.org
Kaiser Foundation Health Plan of the Northwest	Mon. – Fri. 8 a.m. – 7 p.m.	1-800-813-2000 TTY: 1-800-324-8007	www.kp.org
Molina Healthcare of Washington, Inc.	Mon. – Fri. 7:30 a.m. – 6 p.m.	1-800-869-7165	www.molinahealthcare.com
Premera Blue Cross	Mon. – Thurs. 8 a.m. – 5 p.m. Fri. 8:30 a.m. – 5 p.m.	1-800-691-3072 TTY: 1-800-842-5357	www.premera.com
Regence BlueShield	Mon. – Fri. 7:30 a.m. – 5 p.m.	1-800-560-5731	www.regence.com

Washington "Hotline" Phone Numbers

Alcohol and Substance Abuse 1-800-562-1240

Domestic Violence 1-800-562-6025

Emergency Contraceptive Advice 1-888-NOT-2-LATE (1-888-668-2528)

Family Planning 1-800-770-4334

HIV/AIDS (National) 1-800-342-AIDS (1-800-342-2437)

Poison Control 1-800-732-6985

If you have any questions about…	Call…
• **Adding and/or dropping a family member** • **Address changes** • **Income changes** • **Premium amount**	Basic Health toll-free at: 1-800-842-7712 to request forms or to hear recorded information; or 1-800-660-9840 to talk to a Basic Health benefits specialist.
• **Bills received for services** • **Choosing a primary care provider** • **Covered services** • **Services received from providers** • **Waiting periods**	Your health plan. (See the phone number on the inside cover of this handbook.)
• **Your medical care** • **Referrals to specialists**	Your primary care provider.
• **Premiums, payments, billing, or refunds**	Basic Health toll-free at: 1-800-842-7712 for 24-hour, self-service verification of premium payment information; or 1-800-660-9840, then follow the recorded instructions to speak with an accounting representative.

When you call or write us…

Be sure to include your **name**, **subscriber I.D. number**, **address**, and a **daytime phone number**.

If you speak with a representative, it is helpful if you note the date of the call, whether the representative was with Basic Health or your health plan, and the name of the person you talked to. If you are enrolled as part of an employer, home care agency, or financial sponsor group, first contact your group representative (usually your payroll officer or financial sponsor representative). He or she may have the information you need, or may need to know about a change you're reporting.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Si desea ayuda en español, llame al 1-800-321-0291.

Для обслуживания на русском языке, позвоните, пожалуйста, по телефону 1-800-387-8224.

한국어로 도움을 원하시면 1-800-324-1658로 연락하십시오.

Nếu quý vị muốn được giúp bằng tiếng Việt, xin gọi số 1-800-423-2231.

At A Glance

Basic Health office hours ..... Monday through Friday, 7:30 a.m. until 5:30 p.m.

Mailing addresses

Premium payments (with payment stub only) ..... P.O. Box 34270, Seattle, WA 98124-1270

General correspondence ..... P.O. Box 42683, Olympia, WA 98504-2683

Basic Health appeals (see pages 20-21 first) ..... P.O. Box 42690, Olympia, WA 98504-2690

Basic Health Web site .....www.wa.gov/hca/basichealth.htm
(Includes provider directory, *How Much Will Basic Health Coverage Cost?*, and other useful information)

Family additions (report new family members even if not enrolling them)

If you are adding (a):	*Application form must be received by Basic Health:*
Newborn	Within 60 days of birth
Newly adopted child	Within 60 days of placement for adoption
Other child	Within 30 days of marriage or custody change
New spouse	Within 30 days of marriage
Yourself or an eligible family member due to loss of other coverage	Within 30 days of loss

If you are pregnant .....Notify Basic Health immediately (see page 17)

Other account changes

Income change ..... Notify Basic Health if any source of income increases or decreases enough to change your income band (as shown in the *How Much Will Basic Health Coverage Cost?* brochure). **You are required to report the income change no more than 30 days after the end of the first month at the new income level.** See important information on pages 6 and 10.

Address change .....Use the *Change Form* included with your monthly billing statement

Premiums

Premium due date ..... 5th of each month (pays for the following month of coverage)

Basic Health's full-premium program ..... See pages 24-25

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(continued on next page)

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CHAPTER ONE: Introduction

What is Basic Health?

Basic Health offers high-quality, affordable health coverage to eligible Washington State residents. Basic Health is a state program administered by the Washington State Health Care Authority (HCA). The HCA contracts with health plans to offer Basic Health and Basic Health *Plus* to eligible Washington State residents. Each health plan, in turn, contracts with hospitals, clinics, pharmacies, physicians, and other providers to form that health plan's network of providers who deliver health services to Basic Health and Basic Health *Plus* members. For some Basic Health *Plus* and Maternity Benefits Program services, such as dental and vision care, the state pays the provider directly.

As a Basic Health member, your monthly premiums are based on your (and your dependents') age, family size, income, and the health plan you choose. If your income increases, you may pay a higher percentage (up to the full cost) of your premium and, in some cases, you may be disenrolled or transferred to Basic Health's full-premium program. For more information on income guidelines, refer to *How Much Will Basic Health Coverage Cost?* on our Web site or call 1-800-660-9840.

You must follow your health plan's guidelines and procedures to receive the benefits described in this handbook. You may also be required to provide your health plan or Basic Health with information (including medical records) needed to determine eligibility for benefits or to process claims. Guidelines and procedures may vary from health plan to health plan. Be sure to read your health plan's materials for details and call your health plan first if you have any questions about benefits.

How do I use this handbook?

This handbook serves as your certificate of coverage. It describes the services and supplies covered by Basic Health, and the rules you must follow when using this coverage. This handbook is subject to the administrative rules of Basic Health, chapter 182-25 of the Washington Administrative Code (WAC), as amended.

Keep your *Member Handbook* in a convenient place and refer to it whenever you have a question about your benefits. We've provided some handy resources, including forms for reporting income changes and a list of phone numbers in case you have questions not answered here.

Basic Health sometimes sends publications such as *Hot Policy Pages*, open enrollment information, or other notices to keep you informed and notify you of changes. These may include amendments to the information in this handbook. You should keep these publications with your *Member Handbook* for future reference.

For the most part, this handbook is written for all members of Basic Health. However, additional information for the Maternity Benefits Program and Basic Health *Plus*, and for members of Basic Health for Groups, will be contained at the end of many sections. If you're a member of one of these programs, look for the identifier as shown below:

- **+** Basic Health *Plus*
- **M** Maternity Benefits Program, or
- **G** Groups

Throughout this handbook, "you" generally refers to the main subscriber on your Basic Health account. In Basic Health *Plus* sections, "you" generally refers to an adult who will be reading and referring to Basic Health *Plus* coverage on behalf of his or her children.

Full-premium members

If you're enrolled in Basic Health's full-premium program, see pages 24-25 for specific details. Sections that have been amended are marked. See pages 2 and 3 for more information on the various Basic Health programs.

CHAPTER TWO:
How Does Basic Health Work?

Who is eligible for Basic Health coverage?

Basic Health is available to any Washington resident who:

- Meets income guidelines;
- Is not eligible for Medicare; and
- Is not institutionalized (at the time of enrollment) in a government-funded facility that has historically provided health care.

You are considered "eligible" for Medicare if you are eligible for free Medicare coverage or are eligible to buy Medicare coverage.

Family members who should be listed as dependents on your account include your:

- Spouse (unless legally separated).
- Unmarried children including stepchildren; legally adopted children; and children placed in your home for purposes of adoption, or other children for whom you provide documentation of legal guardianship (such as a copy of a court order); who are:
  - Under age 19; or
  - Under age 23, if full-time students at an accredited school.
- Legal dependents of any age, who are not capable of self-support due to disability. You must provide documentation of legal guardianship, such as a copy of a court order.

Family members who are not eligible for coverage on your account may be eligible to enroll separately—for example, a child who reaches age 19 and is not disabled or attending school full time. To apply for Basic Health coverage, this child must complete a separate application and enroll under his/her own account.

BASIC HEALTH *PLUS*

Basic Health *Plus* is a Medicaid program for children under age 19; it's run by Basic Health and the Department of Social and Health Services' Medical Assistance Administration, which will be referred to as "DSHS" throughout the rest of this handbook. With Basic Health *Plus*, eligible children receive additional health care coverage such as dental care, vision care, and physical therapy at no cost to you. Medicaid pays the entire cost for Basic Health *Plus* coverage, including monthly premiums and copayments. Children enrolled in Basic Health *Plus* will receive services through the same health plan that provides your Basic Health coverage.

Your children may be eligible for Basic Health *Plus* if you meet Basic Health income guidelines. To be eligible, the children must be your legal dependents, live in your home, and be:

- Under age 19;
- U.S. citizens, or immigrants who arrived in the U.S. on or before August 22, 1996;
- Not enrolled in any other managed care plan, including TRICARE; and
- Not receiving Temporary Assistance for Needy Families (TANF) grants from DSHS.

If you would like to transfer your child's coverage from Basic Health to Basic Health *Plus*, call 1-800-842-7712 for an application.

BASIC HEALTH FOR GROUPS

In addition to individual coverage, Basic Health is available to groups. Employers, home care agencies, and financial sponsors may enroll their employees or sponsored members in a Basic Health group account. If you are covered through a group account, your employer or financial sponsor pays your

premium, but may collect part of it from you. Under group membership, your main contact with Basic Health will be through your group representative.

Basic Health for foster parents and personal care workers

If you are currently licensed by DSHS as a foster parent or under contract with DSHS as a personal care worker, and your income qualifies you for a reduced premium, you may be able to pay an even lower premium for Basic Health coverage. For further information or to request a foster parent or personal care worker application packet, call 1-800-660-9840 or check Basic Health's Web site. To apply for this lower premium, complete the *Certification Form* in the packet and return it to Basic Health, along with the requested documentation.

How the health plans work

Costs, providers and facilities, covered prescription drugs, referral practices, and other guidelines may differ by health plan. However, all the health plans offer the same basic benefit package and require you to choose a primary care provider (PCP) to coordinate or provide your care.

Each health plan contracts with a number of providers and facilities (called the health plan's "provider network"). Your health plan may refer you to a specialist or facility outside the health plan's network if you or your child needs a provider or hospital not available in your health plan's network. You must get your health plan's approval to be treated by a provider or facility not available through your health plan's provider network, except in an emergency (see page 17).

Some health plans may contract with provider groups called subnetworks; **this may restrict your choice of providers.** You may be required to see specialists or use facilities, such as hospitals, which are in the same subnetwork as your PCP. This means that, even if a provider is affiliated with your health plan, the provider's services may not be available to you unless the provider is also affiliated with your PCP.

Call the health plan or your PCP to find out if your PCP can refer you to anyone listed as a provider with that health plan, or if your PCP can refer you to only a selected group of providers within the health plan.

Basic Health *Plus* and Maternity Benefits Program

If you or your dependent are enrolled in Basic Health *Plus* or the Maternity Benefits program and you would like to know more information regarding the Physician Incentive Program (PIP), please call your health plan.

Your primary care provider

Each covered family member must enroll in the same health plan, but may choose a different primary care provider (PCP) within that health plan. Except in an emergency, your primary care provider and staff will provide or coordinate all of your health care needs, including referrals to specialists. Primary care providers may be family or general practitioners, internists, pediatricians, or other providers approved by your health plan. You may change your PCP during the year. Contact your health plan for details on changing providers or for a current list of providers. You may also contact the provider you're considering and ask if he or she contracts with your health plan for Basic Health coverage. When you call a provider, be sure to mention the health plan name and Basic Health, and ask whether the provider participates in the health plan.

To be covered by your health plan, all health services must be provided by your PCP, unless:

- You are referred by your primary care provider (in most cases, the referral must be approved by your health plan); or

- You need emergency care, as described on page 17; or
- You self-refer for women's health care services or covered chiropractic care to a provider who contracts with your health plan.

If you have questions, call your health plan at the number listed on the inside cover of this handbook.

Dependent temporarily out of county/state

If your dependent child is temporarily away at school (or lives away from you part of the time), he or she may still be covered under Basic Health as long as he or she maintains Washington State residency. If possible, select a health plan that provides service to both your home county and the county in which your child is located. Otherwise, Basic Health will cover only emergency care while your child is out-of-state or staying in a county that is not served by your health plan. Any routine services for that child should be scheduled for a time when he or she is home from school. When necessary, Basic Health allows your dependents to enroll in a different health plan under a separate account so that your dependent may receive services within the county where he or she lives. There will be a separate billing for that account.

Basic Health *Plus*

If you cannot drive your child to a health care provider for covered services, call the DSHS transportation broker for your region. Call Medical Assistance Customer Service at 1-800-562-3022 for the transportation broker's phone number. Make sure you have your child's DSHS Medical Assistance I.D. (M.A.I.D.) card and Basic Health *Plus* I.D. card handy when you call.

Self-referral for women's health care services

Female members may seek care for women's health care services without a PCP referral or health plan preauthorization. **You may seek these services from any women's health care provider who contracts with your health plan. Facility services such as those provided by hospitals or outpatient surgical centers may require preauthorization from your health plan.** The following women's health care services are covered under this benefit:

- Maternity care, including prenatal, delivery, and postnatal care.
- Routine gynecological exams.
- Except as specifically excluded, examination and treatment of disorders of the female reproductive system.
- Other health problems discovered and treated during the course of a woman's health care visit, as long as the treatment is within the provider's scope of practice, and the service provided is not excluded.

Any follow-up services for conditions not directly related to maternity care, routine gynecological exams, or disorders of the female reproductive system may require referral and preauthorization by your health plan.

Please note: Women who use the self-referral option may only choose providers who contract with their health plan to provide Basic Health services. You must obtain preauthorization or approval from your health plan if your women's health care provider refers you to another specialist, and your health plan may require preauthorization for any services provided to you by a facility. **Benefits may be denied if you do not follow your health plan's referral and preauthorization requirements.** Please call your health plan for information.

When will my coverage begin?

Basic Health will notify you in writing when your Basic Health or Basic Health *Plus* managed care coverage is effective. It generally takes four to six weeks to process your application once all information is received. Basic Health's reduced-premium program can enroll only a limited number of people. If we reach that limit, Basic Health will delay your coverage. **Please note:** Even if your payment has been processed, your coverage will not begin until after your application has been approved and space is available.

If you marry and you follow the procedures explained in "Family Changes" on page 12, coverage for your new spouse (and stepchildren, if any) will begin on the first day of the month after the enrollment process is complete.

Your newborn (or adopted) child is covered from the date of birth (or placement in your home) if you or a family member are enrolled in Basic Health or Basic Health *Plus*, but only if Basic Health receives your application to enroll the child within 60 days of the birth (or placement). Refer to page 12 for instructions on applying for coverage for a new family member.

If you want to stop Basic Health coverage, see "How to disenroll" on page 14.

Basic Health *Plus* and Maternity Benefits Program

If you or your dependent are enrolled in Basic Health while eligibility is being determined for Basic Health *Plus* or the Maternity Benefits Program, you are charged a premium for that person. If enrollment in Basic Health *Plus* or the Maternity Benefits Program (managed care) is approved for a month for which you have already paid Basic Health premiums, the overpayments will be credited to your account for future months. However, Basic Health premiums will not be credited for months you were covered under DSHS fee-for-service.

Identification cards

After your enrollment in Basic Health, the health plan will send you and your enrolled family members a Basic Health I.D. card. (Some health plans may require that you choose a PCP before they will issue your I.D. card.) The card has important information, including the number to call if you are hospitalized or have questions. If you need care before you receive the card, contact the health plan at the number listed on the inside cover of this handbook. Your enrollment confirmation letter from Basic Health can serve as temporary identification before you receive your card.

Basic Health *Plus* and Maternity Benefits Program

You receive two I.D. cards for each member enrolled in Basic Health *Plus* or the Maternity Benefits Program:

- A Basic Health I.D. card.
- A DSHS Medical Assistance I.D. (M.A.I.D.) card, allowing the member to receive additional Medicaid covered services. You receive a new card each month.

You or your dependent should carry both cards.

Premium payments

Your premiums are due the fifth of the month before the month of coverage; the amount and due date are shown on each month's billing statement. You are sent a statement for coverage approximately six weeks before the month covered by that payment. For example, your statement for August coverage is sent mid-June and your premium is due July 5.

If you do not pay the entire premium on time, your statement for the next month will include a delinquency notice. Your payment for the total amount shown must be received by Basic Health by the due date given on the notice, or your coverage will be suspended for one month. Partial payment, or checks returned for non-sufficient funds or missing signature, will be considered nonpayment and may also result in your suspension or disenrollment.

If your coverage is suspended, your health plan will not pay for any health care services you or your family members receive during that month. Basic Health will send you a notice of suspension, which will tell you the month you will be without coverage and will include a due date for payment if you want to return to Basic Health coverage. If you pay the amount due by that due date, your coverage will be restored on the first day of the following month (you will be without coverage for one month). If your payment is not received by Basic Health by the due date on the suspension notice, you and your family members will be disenrolled from Basic Health and will not be allowed to re-enroll for at least 12 months.

In addition, if your coverage is suspended more than two times in a 12-month period, you and your family members will be disenrolled from Basic Health and will not be allowed to re-enroll for at least 12 months.

Please note: Coverage will continue for any family members enrolled through DSHS Medical Assistance programs (Basic Health *Plus* or the Maternity Benefits Program) as long as they remain eligible for these programs.

Basic Health for Groups

As a member of a group, your employer, home care agency, or financial sponsor will pay your premium, but may collect part of it from you.

If your employer, home care agency, or financial sponsor doesn't pay the premium on time, you may be disenrolled from Basic Health group coverage. If your group is disenrolled, Basic Health will offer you coverage under an individual account, but you may have a period of time without coverage.

Recertification

State law requires Basic Health to periodically verify that our members' income and eligibility information is up to date. Under this "recertification" process, Basic Health subscribers receive a letter requesting copies of their current income and other relevant documentation. Being selected for recertification does not mean that Basic Health believes you have given us the wrong information, but it is a legal requirement.

If you receive this letter, you must send Basic Health all the documentation requested by the due date given. **If you do not send all information requested**, and we cannot verify your continued eligibility for Basic Health, you will be disenrolled and may not re-enroll for at least 12 months. **If you do not send complete income documentation**, we cannot verify your continued eligibility for a reduced premium and, because enrollment in the full-premium program is limited, you may be disenrolled. If you are determined eligible to continue coverage in the full-premium program, and full-premium enrollment is available in your area, you may continue coverage by paying the full cost of your premium. Your copayment responsibilities will change if you are transferred to the full-premium program. See page 25 for specific information regarding full-premium copayments and maternity care. If you were disenrolled because we were unable to verify your continued eligibility for a reduced premium, and our

full-premium program was not available in your area, you may return to Basic Health's reduced-premium program after we receive the required documentation; however, your enrollment may be delayed if space is not available.

Recoupment

Important: You must notify Basic Health right away if your income increases enough to move you to a different income band. Basic Health may verify your income through contact with other state or federal agencies. If this shows that you have not reported an income increase which affects your premium, Basic Health may bill you for additional premiums due for past months (called "recoupment"). Washington State law also allows Basic Health to collect a penalty of up to 200 percent of the amount due.

If you had an increase in income and are billed for past premiums, you may be disenrolled unless you pay the amount due, according to the billing schedule established by Basic Health. If you are disenrolled under these circumstances, you will not be allowed to re-enroll for at least 12 months **and** until your account balance is paid. Also, your account will be referred to a collection agency; you will be responsible for any fees or charges associated with the collection proceedings, as well as the full balance due on your account.

Rights and responsibilities

As a Basic Health or Basic Health *Plus* member, you and your enrolled dependents have the right to:

- Understand Basic Health, Basic Health *Plus*, or the Maternity Benefits Program.
- Get readable, understandable notices or have the materials explained or interpreted.
- Receive timely information about your health plan.
- Get courteous, prompt answers from your health plan and Basic Health.
- Be treated with respect, dignity, and a right to privacy by Basic Health, Basic Health *Plus*, and Maternity Benefits Program providers.
- Obtain information about all medical services covered by Basic Health, Basic Health *Plus*, and DSHS Medical Assistance.
- Choose your health plan and primary care provider.
- Receive proper medical care without discrimination no matter what your health status or condition, sex, ethnicity, race, marital status, or religion, consistent with Appendices A and B of this handbook.
- Get all medically necessary covered services and supplies listed in the Basic Health or Basic Health *Plus* Schedule of Benefits, subject to the limits, exclusions, and copayments described in Appendices A and B, or, if you're a full-premium member, in Chapter Six of this *Member Handbook*.
- Participate in decisions about your and your child's health care, including having a candid discussion of appropriate or medically necessary treatment options, regardless of cost or coverage.
- Get medical care without a long delay.
- Refuse treatment and be told of the possible results of refusing.
- Expect your and your child's records or conversations with providers to be kept confidential.
- Obtain a second opinion by another health plan provider when you disagree with the initial provider's recommended treatment plan.
- Make a complaint about the health plan or providers and receive a timely answer.
- File an appeal with your health plan, DSHS, or Basic Health if you are dissatisfied with a decision (please refer to pages 21-23).

- Receive a review of a Basic Health appeal decision, if you disagree with it.
- Receive a fair hearing from DSHS, regardless of whether you filed an appeal with your health plan (Basic Health *Plus* and Maternity Benefits Program only).
- Change your primary care provider for a good reason (call your health plan for assistance).

As a Basic Health or Basic Health *Plus* member, you and/or your dependent have the responsibility to:

- Report changes of address, family status, or income when they happen by submitting appropriate forms or calling Basic Health at 1-800-660-9840.
- Select one of the health plans available in your area.
- Select a primary care provider from your health plan before receiving services.
- Cooperate with your health plan and DSHS to help obtain any third party payments for medical care.
- Report to your health plan any outside sources of health care coverage or payment, such as insurance coverage for an accident.
- Inform your or your child's primary care provider of medical problems and ask questions about things you do not understand.
- Decide whether to receive a treatment, procedure, or service.
- Get medical services from (or coordinated by) your or your child's primary care provider, except in an emergency or in the case of a referral.
- Get a referral from the primary care provider before you go, or take your child, to a specialist.
- Pay Basic Health copayments in full at the time of service (applies only to Basic Health members).
- Pay your Basic Health premiums in full by the date they are due (applies only to Basic Health members).
- Not engage in fraud or abuse in dealing with Basic Health, Basic Health *Plus*, DSHS, your health plan, your primary care provider, or other providers.
- Keep appointments and be on time, or call the provider's office when you or your child are going to be late or can't keep the appointment.
- Keep the DSHS M.A.I.D. card (Basic Health *Plus* and Maternity Benefits Program members only) and Basic Health I.D. card with you or your child at all times.
- Notify the health plan or primary care provider within 24 hours or as soon as is reasonably possible of any emergency if services have been provided outside the health plan.
- Use only your selected health plan and primary care provider to coordinate services for your family's medical needs.
- Comply with requests for information, such as previous medical records or other coverage, by the date requested.
- Submit updated proof of eligibility when requested.
- Cooperate with your primary care provider and referred providers by following recommended procedures or treatment.
- Work with your health plan and providers to learn how to stay healthy.

Basic Health *Plus* and Maternity Benefits Program

Along with the rights and responsibilities shown above, members of Basic Health *Plus* and the Maternity Benefits Program also have the right to:

- Have language interpreters and interpreters for deaf and hearing-impaired, if necessary, during medical appointments, when talking with the health plan providers and administrators, and during a fair hearing or review of a complaint.
- Enrollees shall have the right to change enrollment prospectively, from one health plan to another without cause, each month.

Informed Consent

You have the right to give your consent. You have the right to know about the possible side effects of your care and give your consent before you get care. Be sure to ask your provider about the side effects of your care.

Advance Directives

Advance Directives put your choices into writing. They may also name someone to speak for you if you are not able to speak. Washington State law has two kinds of Advance Directives:

1. Durable Power of Attorney for Health Care – This names another person to make medical decisions for you if you are not able to make them for yourself.
2. A Directive to Physicians (Living Will) – A statement that you want to die naturally and don't wish to have treatments that will prolong your life.

Account privacy

Without your written authorization, the Health Care Authority cannot release personal account details such as eligibility, enrollment, monthly premium, or payment to anyone but you or your health plan.

Exceptions:

- If you are enrolling as part of an employer, home care agency, or financial sponsor group, limited information may be released to your group representative. Ask your group representative for details.
- Information about a minor child will be released to either parent.
- If you are applying for or enrolling in Basic Health *Plus* or the Maternity Benefits Program, or as a foster parent, personal care worker, or home care worker, some information may be shared with DSHS.

If you want to let someone else, such as a friend or relative who is helping you, access your account details, you'll need to send written authorization to Basic Health. Be sure to sign and date your letter and include the person's name, their relationship to you, and what information you want released to them. Only the information you specify will be released, so if you want to give this person access to all your account information, you will have to specifically state that they can have access to all account information. You will also need to specify if this permission is being granted for a specific time period or for as long as you remain enrolled in Basic Health. When this person calls, they'll need your Basic Health subscriber I.D. number, and will be asked for other identifying information.

Chapter Three: Making Changes

How to make changes to your account

To make some types of account changes or to request forms, use the detachable *Change Form* included with your billing statement. We have also included the forms for reporting income changes at the back of this handbook. To request additional forms for account changes, you may call our 24-hour, automated, self-service phone line, 1-800-842-7712 or visit our Web site. You may also write to Basic Health at P.O. Box 42683, Olympia, WA 98504-2683.

Income changes

(Full-premium members: Please refer to page 24.)

If your income or family size changes, your monthly premium may change, too. If your family income increases enough to affect your premium, you are required to report the income change to Basic Health within 30 days of the end of the first month. Be sure to also notify Basic Health if your income decreases or if you are no longer receiving income you previously reported. After your income changes, you will need to continue paying your premium as billed until we notify you of the new premium amount. (See additional information under "Recertification" on pages 6 and 7 and "Recoupment" on page 7.)

Basic Health uses federal income guidelines to help determine eligibility and monthly premiums for our reduced-premium program. Below are Basic Health's income bands, in effect until July 1, 2002. All Basic Health members will receive a *Hot Policy Page* in May 2002, which will amend the income bands printed here.

Family Size							Income Bands
1	2	3	4	5	6	7	
$0 – $465.29	$0 – $628.87	$0 – $792.45	$0 – $956.04	$0 – $1,119.62	$0 – $1,283.20	$0 – $1,446.79	A
465.30 – 715.83	628.88 – 967.49	792.46 – 1,219.16	956.05 – 1,470.83	1,119.63 – 1,722.49	1,283.21 – 1,974.16	1,446.80 – 2,225.83	B
715.84 – 894.79	967.50 – 1,209.37	1,219.17 – 1,523.95	1,470.84 – 1,838.54	1,722.50 – 2,153.12	1,974.17 – 2,467.70	2,225.84 – 2,782.29	C
894.80 – 1,002.16	1,209.38 – 1,354.49	1,523.96 – 1,706.83	1,838.55 – 2,059.16	2,153.13 – 2,411.49	2,467.71 – 2,763.83	2,782.30 – 3,116.16	D
1,002.17 – 1,109.54	1,354.50 – 1,499.62	1,706.84 – 1,889.70	2,059.17 – 2,279.79	2,411.50 – 2,669.87	2,763.84 – 3,059.95	3,116.17 – 3,450.04	E
1,109.55 – 1,216.91	1,499.63 – 1,644.74	1,889.71 – 2,072.58	2,279.80 – 2,500.41	2,669.88 – 2,928.24	3,059.96 – 3,356.08	3,450.05 – 3,783.91	F
1,216.92 – 1,324.29	1,644.75 – 1,789.87	2,072.59 – 2,255.45	2,500.42 – 2,721.04	2,928.25 – 3,186.62	3,356.09 – 3,652.20	3,783.92 – 4,117.79	G
1,324.30 – 1,431.73	1,789.88 – 1,935.09	2,255.46 – 2,438.45	2,721.05 – 2,941.81	3,186.63 – 3,445.17	3,652.21 – 3,948.53	4,117.80 – 4,451.88	H

If you begin receiving social security disability benefits, whether or not your income changes, you must notify Basic Health. This may affect your eligibility for Basic Health. Please also refer to the following list when sending income information to Basic Health.

Include **income from the following sources:**

- Salaries, wages, commissions, tips, and work study income
- Self-employment and rental income
- Unemployment income and strike benefits
- Social security benefits and Supplemental Security Income
- Retirement and pensions
- Child support, family support, and alimony
- Insurance benefits
- Income from interest, including interest on IRA distributions, dividends, trusts, annuities, and royalties
- Veterans' benefits and military allotments
- Labor and Industries benefits
- Public assistance (Department of Social and Health Services cash assistance)
- Estate income, gambling/lottery winnings
- Other income if not listed under "Do not include"

Do *not* include:

- Income, such as wages, earned by dependent children
- Capital gains
- Any assets drawn down as withdrawals from a bank, or proceeds from the sale of property, such as a house or car
- Tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments, or compensation for any injury (except workers' compensation)
- Income from a family member who lives in another household, when that income is not available to you or eligible dependents seeking Basic Health enrollment
- University scholarships, grants, fellowships, or assistantships
- Non-cash benefits (such as food stamps, school lunches, or housing assistance)
- Payments for adoption support received from the Department of Social and Health Services

Reporting income changes. Please send the *Monthly Income Worksheet* (included in the back of this handbook), along with:

- Copies of your family's pay stubs and proof of gross income (before taxes) from all sources for the entire month or last 30 days; and
- A copy of your federal income tax return for the most recent year (W-2 forms are not acceptable). Regardless of whether you filed by mail or electronically, your federal income tax return must be signed by you (your tax preparer's signature is not sufficient). If you were not required to file or do not have a copy of your tax

return for the most recent year, you must send a transcript of your account (showing gross interest income and self-employment income) or Verification of Nonfiling Status, which you can request from the IRS by calling 1-800-829-1040.

- A *Self-Employment/Rental Income Worksheet*, if required. For additional information or to see if you need to send this form, read the instructions with the worksheet in the back of this handbook.

Basic Health will notify you of how your change in income may affect your monthly premium or eligibility. This notice, called a "personal eligibility statement," may explain that you have an additional premium due. Please review it carefully.

Income averaging. If your income (other than self-employment/rental income) varies greatly from month to month, and the variation is not the result of a change in source of income, Basic Health can determine your premium based on an average of your income over three months. To request income averaging, send a written request to Basic Health, along with the required documentation of your income for the most recent three months and your signed federal income tax form (IRS Form 1040) or tax transcript for the most recent year. The premium that is set based on average income will be "locked in" for six months, unless there is a major change in your family circumstances during that time (such as a gain or loss of a job, or marriage or divorce) or all Basic Health premiums change.

Self-employment or rental income. If you are reporting self-employment or rental income, Basic Health will require that your premium be based on an average of your income, using a 12-month history of your self-employment or rental income and expenses, unless you have had the business or rental property for less than 12 months.

Family changes

(Full-premium members: Please refer to page 24.)

You may add eligible family members to your Basic Health account during open enrollment, if you meet income guidelines. At other times during the year, you may enroll family members only if your status changes because of:

- Marriage (application must be received at Basic Health within 30 days of the marriage, even if your new spouse is not applying for coverage).
- Birth or adoption (application must be received by Basic Health within 60 days of the birth or placement of the child).
- Loss of other continuous coverage for which you previously either left Basic Health or waived Basic Health coverage (application must be received by Basic Health within 30 days of the loss and you will be required to provide proof of continuous coverage).
- Change in legal custody of a child or disabled dependent (application and proof of legal custody or guardianship must be received by Basic Health within 30 days of the custody change).

To enroll a new family member, please call 1-800-842-7712 to request the *Family Changes Form* or visit Basic Health's Web site. Be sure to follow the instructions included with the form. You will need to send Basic Health current documentation of family income, as well as any other income changes that could affect your monthly premium.

If you do not provide the necessary form or documentation within the time frames stated above, the new family member will be added to your account for family size only (which may change your monthly premium), but cannot enroll until the next open enrollment period.

To add a newborn or newly adopted child, you may also use the detachable *Change Form* included with your monthly billing statement.

Page 5 describes when coverage begins for new family members. Please note that Basic Health's reduced-premium program can enroll only a certain number of people. If we reach that limit, Basic Health may be required to delay your coverage.

Separation or divorce. To take action on your account due to separation or divorce, please call 1-800-842-7712 to request a *Family Changes Form* or visit Basic Health's Web site. Be sure to follow the instructions included with the form. You will need to send Basic Health current income information and proof of residency. If there are children on your account, you will also need to send a copy of the court order determining a parent's custody or obligation to provide for the child's health care coverage.

When you notify Basic Health of a change in family size that could also change your income (such as a marriage, divorce, or death), you will be required to submit proof of your current income.

Address changes

If you move, call Basic Health immediately at 1-800-660-9840, complete the detachable *Change Form* included with your billing statement and return it with your payment, or write to Basic Health at P.O. Box 42683, Olympia, WA 98504-2683. Include your subscriber I.D. number, your name, new address and county, your old address, and your phone number. Be sure to say if your new address is permanent or temporary (less than six months), and if your mailing address is different from your street address.

If you move within Washington State, or your address changes, you must provide Basic Health with your new address **within 30 days**. If you move out of your health plan's service area, you will be required to select a new health plan. Until your coverage can be transferred to a health plan that serves the area where you live, you will need to travel to the area served by your old health plan for any services except emergency services.

Please note: We routinely verify addresses with the U.S. Postal Service, so please be sure to file a change of address with your post office, as well.

Changing health plans

(Full-premium members: Please refer to page 24.)

During open enrollment, you may change your health plan (if you have more than one plan available in your area) or enroll eligible family members as long as you meet income and eligibility requirements. Basic Health will send you open enrollment materials, which will indicate the effective date of these changes and provide information on available health plans and the monthly premium for each. You'll be notified of each upcoming open enrollment period and given instructions for making changes.

Other than during open enrollment, you will not be allowed to change health plans unless you are able to show "good cause" for the change. An example of what would be considered "good cause" is moving to a county where your current health plan is not offered. It is not considered good cause for a change in health plans if your doctor or other provider is no longer participating with your health plan.

When you are given an opportunity to change health plans, remember that each health plan contracts with different providers and has its own prescription drug formulary (list of covered drugs). You should call the health plan or your provider to find out if your provider contracts with the health plan you are considering. If you take any prescription medications, you also should contact the health plan you are considering to see if your medications will be covered.

If you change health plans, any services you had approved under your previous health plan may need to be approved again by your new health plan. Check with your health plan for further information.

Basic Health *Plus* and Maternity Benefits Program

Enrollees have the right to change enrollment prospectively, from one health plan to another, without cause, each month.

Basic Health for Groups

If you are enrolled in a group account, make sure your employer or sponsor is aware of any changes in your income or family circumstances; either you or your employer or sponsor must notify us of those changes.

If you are enrolled in a group account through your employer, a change in your income or family size may affect the amount you are required to contribute toward your coverage. Contact your employer or payroll officer if you have questions about those changes.

If you are no longer eligible for employer, home care agency, or financial sponsor group coverage and you still meet income guidelines, Basic Health will offer you coverage under an individual account and you will be required to pay the premium for your continued coverage.

If you are transferring from an individual account to a group account, or vice versa, contact Basic Health to notify us of the change.

Disenrollment and re-enrollment

How to disenroll

(Full-premium members: Please refer to page 24.)

You may disenroll from Basic Health or Basic Health *Plus* coverage for yourself, a family member, or your entire family at any time by notifying Basic Health by phone at 1-800-660-9840, or in writing (P.O. Box 42683, Olympia, WA 98504-2683). The notification must include:

- Your name and Basic Health subscriber I.D. number;
- The name of each person you are disenrolling;
- Reason for disenrolling (especially if due to other insurance, Medicare, or Medicaid); and
- The month you want coverage to end. Coverage will end the last day of the month you indicate, but no sooner than the next coverage month. To qualify for a refund of your premium payment, we need to receive your request to disenroll at least 10 days before the first of the month the payment was to have covered.

If you voluntarily disenroll from coverage, any remaining family members may continue with Basic Health. Remaining family members enrolled in Basic Health *Plus* or the Maternity Benefits Program through DSHS may stay with that program as long as they are eligible, even if your coverage is suspended or you are disenrolled from Basic Health for failing to pay your required premium.

You may not remain enrolled in Basic Health if you:

- Move out of Washington State (or leave the state for more than six months in a row);
- Become eligible for Medicare (either free or purchased Medicare coverage).
- Have income above Basic Health's income guidelines and do not live in a county served by a health plan accepting enrollment in Basic Health's full-premium program.
- Do not pay the required premium when due, or your employer or financial sponsor does not pay the required premium when due. In addition, if your coverage is suspended more than two times

in a 12-month period, you and your family members will be disenrolled from Basic Health and will not be allowed to re-enroll for at least 12 months.

- Do not pay the amount due for recoupment of a subsidy overpayment by the due date (see "Recoupment" on page 7).
- Engage in any form of fraud against Basic Health or your health plan or its providers, or knowingly provide false information.

You also may be disenrolled from Basic Health if you:

- Pose a risk to the safety or property of Basic Health or your health plan, or their staff, providers, patients, or visitors.
- Refuse to accept or follow procedures or treatment recommended by your PCP and determined by your health plan's medical director to be essential to your health (or the health of your child), and you have been told by your health plan that no other treatment is available.
- Have repeatedly failed to pay copayments on time.

The above conditions for loss of eligibility also apply to family members enrolled on your Basic Health account.

If your coverage ends, you'll receive a written notice describing the reason and the date your coverage will end.

Basic Health *Plus*

If your child is no longer eligible for Basic Health *Plus* (for example, due to age or a change in income or family status), you will receive notice from Basic Health or DSHS. To request that your child's enrollment be continued under Basic Health, you must respond to Basic Health within 30 days of that notice.

Basic Health for Groups

When your employer coverage ends, you may have a choice of continuing coverage through COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) or becoming an individual member of Basic Health. Under COBRA, you would be able to continue your coverage for up to 18 months; however, you would have to pay the full cost of your coverage, including any premium share that had been paid by your employer. Contact your employer directly to find out if you are eligible for COBRA coverage. Basic Health may also offer you individual coverage.

How to re-enroll

Re-enrollment procedures depend on the reason your coverage ended and the time since you last had coverage. At the time you re-apply for Basic Health, you may be required to submit a new application, new documentation of income and residency, and proof of other continuous coverage. Because Basic Health enrollment is limited, you may have to wait until space is available before you can re-enroll.

Generally, when you disenroll from Basic Health, you will be required to wait 12 months before you can re-enroll. However, the wait for re-enrollment will be waived if:

- You left for other coverage, and you re-apply for Basic Health within 30 days of losing other continuous coverage (you will be required to provide proof of continuous coverage); or
- You move out of the state, then move back and establish residency; or
- You were disenrolled because you were no longer eligible for reduced-premium Basic Health coverage, and no health plan offered Basic Health full-premium coverage in your county, but you have now become eligible for coverage.

Chapter Four: What's Covered?

Covered services and supplies

The listing of services covered under Basic Health, called the "Schedule of Benefits," is contained in Appendix A of this handbook. If you have questions about a particular medical condition or Basic Health benefit, contact your health plan directly at the number listed on the inside front cover of this handbook.

Basic Health *Plus* and Maternity Benefits Program

Basic Health *Plus* and Maternity Benefits Program-covered services and supplies are the same as those through the DSHS Medicaid program. A complete listing of covered services and supplies is located in Appendix B. In addition to all Basic Health-covered services and supplies in Appendix A*, Basic Health *Plus* and the Maternity Benefits Program cover:

- Dental services.
- Medically necessary durable medical equipment, such as wheelchairs and hospital beds.
- Vision services (including eye exams or eyeglasses).
- Speech therapy, occupational therapy, and expanded physical therapy.

Please note: Basic Health *Plus* and Maternity Benefits Program members will not be charged copayments or missed appointment fees.

Your child may receive vision care or dental services from any DSHS-participating provider who is willing to treat him or her. You can go to your primary care provider for a referral for vision or dental services if you wish, but you are not required to do so. Your health plan will cover the other services only as specified in Appendix B, and only if you have a referral from your PCP. If your child has reached your health plan's limits for one of these services, you may be able to get additional help through other DSHS programs. For more information on covered services and limits, call the Medical Assistance Customer Service Center at 1-800-562-3022.

Pre-existing condition waiting period

- If you did not have similar coverage in the three-month period prior to your application or enrollment, you must wait **nine** months from the day your coverage begins before Basic Health will cover pre-existing conditions (as defined below), except for maternity care and prescription drugs.
- If you had health care that was similar to Basic Health at any time during the three months just before you applied for or were enrolled in Basic Health, your waiting period for treatment of a pre-existing condition may be waived or shortened as described in "Limitations and exclusions," page 34.
- A pre-existing condition is defined as an illness, injury, or condition for which, in the **six** months immediately preceding a member's effective date of enrollment in Basic Health:
  - Treatment, consultation, or a diagnostic test was recommended for or received by the member; or
  - Medication was prescribed or recommended for the member; or
  - Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment.

*Basic Health *Plus* covers some services differently than Basic Health. Please refer to Appendix B for more information.

For all members:

- You must be enrolled in Basic Health for 12 months in a row before you will be covered for organ transplant procedures for a pre-existing condition. Further information on the waiting period for organ transplant procedures is provided in the Basic Health "Schedule of Benefits" on page 29.

Basic Health *Plus* and Maternity Benefits Program

There is no pre-existing condition requirement for children covered under Basic Health *Plus* or for pregnant women enrolled in the Maternity Benefits Program.

If you need emergency care

Emergency care is covered 24 hours a day, seven days a week. (For additional information, including a definition of "emergency," refer to page 30 of this handbook.) To receive benefits from your health plan for emergency care, it is important to follow these steps:

- Depending on the severity of the problem, go directly to the nearest emergency room, call 911, or call your primary care provider.
- If you are admitted to a hospital or other health care facility, call (or have a friend, family member, or staff member call) your health plan or primary care provider within 24 hours or as soon as is reasonably possible.
- See (or be referred by) your primary care provider for follow-up care.

Important: If you do not follow these instructions, your coverage for emergency services may be limited to the amount that would have been paid if you had notified your PCP. (See "Emergency Care" on page 30.) You are responsible for paying any balance. If the case is determined not to be an emergency (whether or not you follow the instructions), you will be responsible for all costs.

If you are pregnant

(Full-premium members: Please refer to page 25.)

If you become pregnant, call 1-800-660-9840 right away to notify Basic Health of your pregnancy.

We will mail a Basic Health *Maternity Benefits Application* for you to complete. The Maternity Benefits Program is a Medicaid program jointly administered with the Department of Social and Health Services' (DSHS) Medical Assistance Administration (MAA). The program allows you to receive maternity benefits through the same health plan you choose for your Basic Health coverage. When you are choosing a provider for your maternity services, you should always verify that the provider contracts with your chosen health plan to provide Maternity Benefits Program services through Basic Health.

DSHS determines eligibility for the Maternity Benefits Program based on Medicaid eligibility criteria. (Medicaid will require a written verification of the pregnancy from a licensed doctor, nurse, or medical laboratory, and will ask for an estimated due date. Home pregnancy tests are not accepted for proof of pregnancy.)

Basic Health provides coverage for maternity services for only 30 days after your doctor verifies your pregnancy, unless you apply for the Maternity Benefits Program. So, you must submit your Basic Health *Maternity Benefits Application* within 30 days after your pregnancy is verified to continue maternity coverage. If you do not apply for the Maternity Benefits Program, you will be responsible for the full costs of any maternity services received more than 30 days after your pregnancy is verified.

The Medical Assistance Administration will tell you if you are or are not eligible for the Maternity Benefits Program. Once your enrollment in the Maternity Benefits Program is complete, you will not have monthly premiums or copayments, and you will continue to receive your care through your Basic Health health plan. However, you will need to continue paying your Basic Health premiums until the effective date of your enrollment in the Maternity Benefits Program. Your enrolled family members will still be covered through Basic Health, and you will still be responsible for paying premiums for them.

If you do not meet citizenship requirements, you may be eligible for other Medical Assistance programs that cover maternity care. To receive these benefits through other Medical Assistance programs, you must report your pregnancy to Basic Health and provide written verification of your pregnancy.

If you have completed the application process for the Maternity Benefits Program and submitted all the required documentation, but you have been told you are not eligible for DSHS maternity benefits, Basic Health will cover maternity services you receive while you are enrolled in Basic Health. However, before these costs will be paid, Basic Health must receive a copy of your denial notice from the Medical Assistance Administration.

The Maternity Benefits Program allows you to receive other services often referred to as "First Steps." First Steps coverage includes maternity support services such as childbirth education classes and support, as well as child care and transportation for medical appointments. See the "Schedule of Benefits" (Appendices A and B) for details about differences between Basic Health and Medical Assistance benefits.

When your pregnancy ends

Once your pregnancy ends, it is very important that you notify Basic Health at 1-800-660-9840 right away. An application to add your newborn child to your Basic Health account will be mailed to you. To avoid a break in coverage, Basic Health must receive your completed application for your newborn's coverage within 60 days of the child's birth.

Your medical coverage will resume under Basic Health at the end of your maternity benefits coverage only if your family's Basic Health premiums (if any) have been paid while you were enrolled in the Maternity Benefits Program. For example, if you have a spouse and/or dependent(s) enrolled in Basic Health and they are disenrolled for nonpayment while you are covered through the Maternity Benefits Program, your coverage will continue until the end of your pregnancy. However, at that point, you will lose your coverage, and you and your family (except for children enrolled in Basic Health *Plus*) will not be able to re-enroll in Basic Health until 12 months from the date of your family's disenrollment. In addition, if enrollment limits have been reached, you will be required to wait until space is available for you to re-enroll in the reduced-premium program.

Basic Health *Plus*

If your child is pregnant, or thinks she might be, she should see her primary care provider right away. Once her pregnancy is verified, you must notify Basic Health at 1-800-660-9840.

When your child's pregnancy ends

You must also notify Basic Health at the end of the pregnancy. Newborns are covered under the dependent mother's Basic Health *Plus* coverage until 60 days after birth and are automatically eligible for continued Basic Health *Plus* coverage for the first year of life, (as long as the mother was covered by Basic Health *Plus* at the time of birth). To continue the newborn's Basic Health *Plus* coverage, you must send notice to Basic Health within 60 days of the date of birth (use the *Family Changes Form* or the *Change Form* included with your billing statement). To continue Basic Health *Plus* coverage for her newborn, your child may also need to enroll under her own account.

Please note: Even though you must notify Basic Health of the pregnancy, your child does not need to apply for additional maternity benefits coverage if she is covered under Basic Health *Plus*. Her maternity services will be covered through Basic Health *Plus*.

The right to exercise conscience

Religiously sponsored health plans, health care providers, or employers have the right not to provide benefits or services for termination of pregnancy or other services to which they object because of religious belief or issues of conscience. If your health plan or employer objects to providing a specific service that is normally provided, you will be told how to receive this particular service from another provider, with no added cost to you. Contact your health plan for more information.

If you object to having coverage for termination of pregnancy or other services, you may notify Basic Health in writing. Benefits will not be provided to you for those services; however, your premium will not change.

Chapter Five: Common Problems

What if I receive a bill for covered services?

If you receive care from a doctor or other provider who contracts with your health plan, the provider will usually bill the health plan directly. However, you may receive a bill from a provider who does not contract with your health plan, or from a provider who did not know about your Basic Health coverage. (When you fill out information for your provider, be sure to list the health plan that provides your coverage–not just Basic Health.) If you receive a bill for services that you think are covered by Basic Health, send the bill directly to your health plan at the address on your I.D. card. (Call your health plan at the number listed in the front of this book for details.) Benefits may be denied if your health plan receives the bill more than 12 months after the date you received services. If you have questions about whether the services are covered, call your health plan.

Basic Health *Plus*

If you receive a bill for your children's services:

- Send the bill directly to your health plan at the address on your I.D. card; and
- Call DSHS at the phone number on your M.A.I.D. card.

What do I do if a third party is responsible for my injury or illness?

You or your representative are required to notify your health plan if your provider charges the health plan for treatment of an injury or illness that is the result of another person's or organization's action or failure to act (for example, a fall, an auto accident, or an accident at work). The other person or organization responsible for your injury or illness is called the "third party."

You must notify your health plan promptly, in writing, of all of the following:

- The facts of the injury or illness, including the name and address of any third party you think may be responsible for the injury or illness;
- The name and address of the third party's insurance company, if they are insured;
- The name and address of attorney(s) who will be representing the third party;
- If you plan to file a claim or lawsuit against the third party, the name and address of the person who will be representing you;
- Adequate advance notice of any trial, hearing, or possible settlement of your claim against the third party;
- Any changes in your condition or injury; and
- Any additional information reasonably requested by the health plan.

If you bring a claim or legal action against a liable third party, you must seek recovery of the benefits paid by your health plan.

After you have been fully compensated for all damages you experienced as a result of the accident, your health plan has a right to reimbursement up to the amount of the benefits the health plan has paid, from any recovery you receive. You are required to pay the health plan only the amount that is left over after you have been fully compensated for all of your damages (including pain and suffering and lost wages), up to the amount of the benefits paid.

If your health plan seeks to recover benefits directly from the third party, you must cooperate fully and must not do anything to impair your health plan's right of recovery. Your health plan may bring suit

against the third party in your name, or may join as a party in a lawsuit or claim you have filed. Your health plan will not be required to pay for legal costs you incur, and you will not be required to pay legal costs incurred by your health plan. However, your health plan may agree to share the cost if they choose to be represented by your attorney.

You could be disenrolled from Basic Health for "intentional misconduct" if you:

- Withhold from your health plan information you have about a legally responsible "third party;" or
- Refuse to help your health plan collect from that legally responsible "third party."

How do I file a complaint or appeal?

If you have a complaint or appeal about services from your health plan, its providers, or benefits, contact your health plan directly. You can find their toll-free number on the inside front cover of this book. If you have a complaint about an action taken by Basic Health, call 1-800-660-9840. If you speak to a representative from Basic Health or your health plan, it is helpful if you note the date of the call, the name of the representative, and whether the representative was with Basic Health or your health plan.

Complaints or disputes with your health plan

Your health plan is required to provide you information on its complaint/appeal process when you enroll, when you report a complaint, and with the health plan's notice of an appeal decision.

If you disagree with a decision made by your health plan (such as denial of a claim or benefits interpretation) or have a complaint regarding your health plan's services, providers, or facilities, you must follow your health plan's procedures for resolving disputes. Basic Health staff are available to help you resolve the issue informally, but the matter cannot be appealed to Basic Health. If you file a complaint against a health plan service, provider, or facility, state law limits the information the health plan may provide you regarding the resolution.

If you file a complaint or appeal with your health plan, the health plan must respond within 14 days of receiving it. This response may be a decision or notification of a reason for a delay. However, unless you agree to an additional delay, the decision may not be delayed more than 30 days after the health plan receives your appeal. If waiting for a decision could jeopardize your health, make sure the health plan is aware of that so they can deliver a decision more quickly. Issues that would jeopardize your health must be decided within 72 hours of receiving the appeal.

If you have exhausted your health plan's complaint/appeal process and disagree with the health plan's decision, or if your health plan has not responded to your request within 30 days, you have the right to request a review of the decision by an independent review organization. This can also be done through your health plan. Your health plan is required by law to provide the independent review organization with all information on which the decision was based within 3 business days of receiving the request. You may also be required to provide additional information or documentation needed for the independent review organization's decision.

Complaints or disputes with Basic Health

If you have a complaint or want an explanation of an action taken on your account, write to Basic Health at P.O. Box 42683, Olympia, WA 98504-2683, or call toll-free 1-800-660-9840. A representative will try to resolve your issue.

If you disagree with a Basic Health decision, such as a denial of eligibility, premium, premium adjustment or penalty, change of health plan, or loss of Basic Health membership, you may file a written appeal with Basic Health within 30 days of the notice of the decision. Write to Basic Health Appeals, P.O. Box 42690, Olympia, WA 98504-2690, stating you want to file an appeal. Your letter must include your name, address, Basic Health subscriber I.D. number, a daytime phone number, and a summary of the decision you are appealing and why you believe the decision was incorrect. You should also include any evidence that will help explain or prove that the decision should be changed.

You may ask to explain in person or by phone why you believe the decision was incorrect and should be changed. Be sure to let us know if you will need an interpreter and, if so, what language and dialect you speak.

Within five days of receiving your letter, Basic Health will send written confirmation that your appeal was received. If you have asked for a chance to explain your appeal over the phone or in person, our Appeals Department will contact you to schedule a conference. The conference will be recorded to ensure an accurate record, and you will be questioned as well as given an opportunity to explain your point of view. You should be prepared to give detailed information to support your opinion that the decision was in error.

Your appeal will be reviewed carefully, and Basic Health will mail a written notice of the decision to you within 60 days of receiving your appeal. If additional time is required for investigation of your appeal, you'll be notified in writing and a decision date will be set.

If you disagree with Basic Health's decision on your appeal, you may request a review of that decision by writing to: Basic Health Appeals, P.O. Box 42690, Olympia, WA 98504-2690. Basic Health must receive your letter within 30 days of the date on the notice of Basic Health's appeal decision. In your letter, you should explain that you are requesting a review of Basic Health's appeal decision. Also include a summary of the decision you are contesting, why you believe the decision was incorrect, any information not included in your original appeal that you believe needs to be considered, and a daytime phone number where we can reach you.

The Office of Administrative Hearings will review Basic Health's appeal decisions regarding disenrollment due to nonpayment. A presiding officer from the Health Care Authority will review Basic Health's appeal decisions on all other issues, based on the record of the appeal and any evidence you send. Be sure to include all information you want considered. The presiding officer may contact you for further information. The HCA will notify you in writing of the final decision.

Basic Health *Plus* and Maternity Benefits Program

If you have concerns about your maternity care or your child's treatment or care, follow the steps below.

- Talk to your (or your child's) PCP.
- If you still have a problem, call your health plan and ask to file a complaint (the phone number is on the inside front cover of this book).
- If you cannot solve the problem, call DSHS at 1-800-794-4360 (TTY/TDD users: call 1-800-461-5980).
- If you have a problem not solved by your health plan's complaint/appeals procedure, or if you feel you are not getting the health care you need, you have the right to a DSHS fair hearing. To ask for a fair hearing, call the Fair Hearing Coordinator at your DSHS Community Service Office, or contact the:

  Office of Administrative Hearings
  P.O. Box 42489
  Olympia, WA 98504-2489
  1-800-583-8271

CHAPTER SIX:
Full-Premium Program

In some instances, Basic Health's full-premium program is different from the reduced-premium program. This chapter explains which sections do not apply, and the differences for full-premium members for 2002.

For 2002, Basic Health's full-premium program is not open to **new applicants.**

Family changes

(amends page 12)

The "Family changes" section on page 12 **does apply** to members of the full-premium program, with the **following exception**: Family members who didn't enroll when the rest of the family enrolled, or who didn't enroll within the time allowed for family status changes (marriage, birth, adoption, etc.) cannot enroll. They have missed their opportunity and will not be given this option during open enrollment.

Changing health plans

(amends page 13)

The "Changing health plans" section on page 13 does not apply to members of Basic Health's full-premium program. Full-premium members must remain with their current health plan throughout 2002. If you move out of the area served by your health plan, your coverage will end at the end of the next coverage month.

Loss of eligibility for the full-premium program

(amends page 14 and 15)

The "How to disenroll" section on pages 14 and 15 **does apply** to full-premium program members. **In addition**, you will be disenrolled if no health plan is offering full-premium coverage in the area where you live, or if you move out of your current health plan's service area.

If you are disenrolled because no health plan offered full-premium Basic Health in your area, and you later become eligible to enroll in reduced-premium coverage or another Basic Health program, you will not be required to wait 12 months to re-enroll.

Income changes

(amends pages 10 and 11)

The following information is **in addition to** the section on "Income changes" on pages 10 and 11. If your income decreases enough that you are within our income guidelines, you may be eligible to transfer from the full-premium program to reduced-premium coverage. Check the income guidelines in *How Much Will Basic Health Coverage Cost?* or call 1-800-660-9840 for further information. Income guidelines are also available on our Web site, *www.wa.gov/hca/basichealth*. If you believe you are eligible for the reduced-premium program, send us proof of all family income for the most recent 30 days, along with a signed copy of your federal tax return and any schedules for the most recent year. After review of your income information, Basic Health will notify you of your eligibility for the reduced-premium program.

Covered benefits

(amends Appendix A)

Read the "Covered services" and "Copayments" sections in Appendix A. These same benefits apply to full-premium members, with the exception of copayments and maternity benefits, as indicated below.

Maternity care. Maternity benefits listed on page 28 **are covered**. Full-premium members are not required to submit a denial notice from the Medical Assistance Administration in order to receive these benefits.

Copayments. The table below amends information in Appendix A, page 33, for full-premium members.

Covered service	Your copayment
Physician	
Age 18 and under:	$15 for office or home visit.
Over age 18:	$25 per office or home visit.
Maternity care:	No copayment.
Hospital	If a member's hospital stay continues into the succeeding calendar year, copayments for the new calendar year will not apply for that hospital stay.
Age 18 and under:	$100 **per day**, up to $500 maximum per member per calendar year; no copayment for readmission for the same condition within 90 days.
Over age 18:	$200 **per day**, up to $1,000 maximum per member per calendar year; no copayment for readmission for the same condition within 90 days.
Maternity care:	Maternity care is subject to the copayment.
Outpatient facility	
Non-emergency:	$75 per non-emergency outpatient admission or facility visit; no copayment for readmission for the same condition within 90 days. Maternity care is subject to the copayment.
Emergency:	$75; waived if an inpatient admission results.
Lab and x-ray	No copayment.
Ambulance	$75. No copayment when the health plan requires a member to transfer from a non-contracting facility to a contracting facility, or when transfer to and from a facility is required for the member to receive necessary services.
Preventive care	No copayment.
Maternity care	Copayment applies for inpatient and outpatient facility. No copayment for office or home visit.
Pharmacy	Tier 1: $10 Tier 2: $20 Tier 3: 50%

APPENDIX A: Schedule of Benefits

This "Schedule of Benefits" lists benefits for Basic Health members who meet income guidelines.

If you are a member of Basic Health's full-premium (nonsubsidized) program, be sure to read Chapter Six of this handbook. It will explain the differences between the information in this handbook and the full-premium program.

Services are subject to all provisions of this "Schedule of Benefits," including limitations, exclusions, and copayments. Except as specifically stated otherwise, all services and benefits under Basic Health must be provided, ordered, or authorized by the health plan or its contracting providers. Even if your provider authorizes a service, your health plan may also need to preauthorize the care.

If you have a question about the benefits listed, or are not sure if a service is covered, you should call the health plan's customer service department.

I. Coverage criteria

Members have the right to receive the services outlined in this "Schedule of Benefits" from their health plan when all of the following four coverage criteria are met.

A. The service is required because of a disease, illness, or injury, and is performed for the primary purpose of preventing, improving, or stabilizing the disease, illness, or injury.

B. There is sufficient evidence to indicate that the service will directly improve the length or quality of the member's life. Evidence is considered to be sufficient to draw conclusions if it is peer-reviewed (as defined by the National Association of Insurance Commissioners), is well-controlled, directly or indirectly relates the service to the length or quality of life, and is reproducible both within and outside of research settings.

C. The service's expected beneficial effects on the length or quality of life outweigh its expected harmful effects.

D. The service is a cost-effective method available to address the disease, illness, or injury. "Cost-effective" means there is no other equally effective intervention available and suitable for the member which is more conservative or substantially less costly.

II. Covered services

The following services are covered when coverage criteria are met:

A. Hospital care

The following hospital services are covered:

1. Semi-private room and board, including meals; private room and special diets; and general nursing services.

2. Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room when eligible for Basic Health maternity benefits, anesthesia, radiology, laboratory and other diagnostic services.

3. Normal newborn care following birth while in a contracting facility when not eligible for coverage under the "Maternity care" benefit. Covered services include, but are not limited to, nursery and laboratory services.

4. Drugs and medications administered while an inpatient.

5. Special duty nursing.

6. Dressings, casts, equipment, oxygen services, and radiation and inhalation therapy.

If a member is hospitalized in a non-contracting facility, the health plan has the right to require transfer of the member to a contracting health plan facility at the health plan's expense, when the member's condition is sufficiently stable to enable safe transfer.

If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

Personal comfort items such as telephone, guest trays, and television are not covered.

B. Medical and surgical care

The following medical and surgical services are covered. The health plan may require that certain medical and surgical services be provided on an outpatient basis.

1. Surgical services.

2. Radiology, nuclear medicine, ultrasound, laboratory, and other diagnostic services.

3. Dressings, casts, and use of cast room; anesthesia and anesthesia-related oxygen services.

4. Blood, blood components and fractions (such as plasma, platelets, packed cells, and albumin), and their administration.

5. Provider visits, including diagnosis and treatment in the hospital, outpatient facility, or office; consultations, treatment, and second opinions by the member's PCP, or by a referral provider. Normal newborn care following birth while in a contracting facility when not eligible for coverage under the "Maternity care" benefit. Covered services include, but are not limited to, routine newborn exams and laboratory services.

   Pharmaceuticals that are or would normally be an intrinsic part of a provider visit (inpatient or outpatient) are covered as part of the provider visit.

6. Radiation therapy; chemotherapy.

7. Inpatient and outpatient chiropractic and physical therapy services are covered to a combined maximum of six (6) visits per calendar year, and are covered for only post-operative treatment of reconstructive joint surgery when received within one year following surgery. Diagnostic or other imaging procedures solely for determination of therapy services are not covered. Chiropractic services may be referred or self-referred to contracted providers.

8. Prescription drugs and medications as defined in "Pharmacy benefit."

9. Family planning services provided by the member's PCP or women's health care provider. Contraceptive supplies and devices (such as, but not limited to, IUDs, diaphragms, cervical caps, and long-acting progestational agents) determined most appropriate by the PCP or women's health care provider for use by the member are also covered. Over-the-counter supplies such as condoms and spermicides are covered only when part of a health plan protocol at the health plan's discretion. Elective sterilization is covered.

C. Maternity care

(Full-premium members: Please refer to page 25.) For pregnant reduced-premium Basic Health members who are determined to be eligible for medical assistance through the Department of Social and Health Services (DSHS), Basic Health shall only cover maternity care services for a period not to exceed 30 days following diagnosis of pregnancy.

The following maternity care services are covered for members who are determined to be ineligible for medical assistance through the DSHS: diagnosis of pregnancy; full prenatal care after pregnancy is confirmed; delivery; postpartum care; care for complications of pregnancy; preventive care; physician services; hospital services; operating or other special procedure rooms; radiology and laboratory services; medications; anesthesia; normal newborn care following birth, such as but not limited to, nursery services and pediatric exams; and termination of pregnancy (including voluntary termination of pregnancy).

D. Chemical dependency

Members are eligible to receive residential and outpatient chemical dependency treatment from a health plan-contracting approved treatment program to a maximum benefit of $5,000 in a 24 consecutive calendar month period up to a lifetime benefit maximum of $10,000. Covered residential and outpatient treatment includes services such as diagnostic evaluation and education, and organized individual and group counseling. The hospital copayment applies to intensive inpatient services. Outpatient copayments for residential (other than intensive inpatient) and intensive outpatient services shall not exceed the hospital stay copayment. Health plans may use lower copayments, if applicable, for group sessions. Court-ordered treatment will be covered only if determined by the health plan to meet coverage criteria.

In determining the $5,000 limit, the health plan reserves the right to take credit for chemical dependency benefits paid by any other group medical plan on behalf of a member during the immediate preceding 24 consecutive calendar month period. In determining the $10,000 lifetime limit, the health plan reserves the right to take credit for chemical dependency benefits paid under Basic Health on behalf of the member from January 1, 1988.

E. Mental health services

Mental health services are covered as follows:

Inpatient care in a participating hospital or other appropriate, licensed facility approved by the health plan is covered in full (subject to copayment) up to 10 days per calendar year.

Outpatient care, including individual and family counseling, is covered in full up to 12 visits per calendar year after the copayment per visit for individual sessions. Health plans may use lower copayments, if applicable, for group sessions. Visits for the sole purpose of medication management are exempted from the 12-visit limit, and are instead covered as other provider visits.

Court-ordered treatment will be covered only if determined by the health plan to meet coverage criteria.

F. Organ transplants

Services related to organ transplants, including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care, are covered. This benefit includes covered donor expenses.

Heart, heart-lung, liver, bone marrow including peripheral stem cell rescue, cornea, kidney, and kidney-pancreas human organ transplants are covered when coverage criteria are met.

Organ transplant recipient: All services and supplies related to the organ transplant for the member receiving the organ, including transportation to and from a health plan-designated facility (beyond that distance the member would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided the member has been accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol.

Organ transplant donor: The donor's initial medical expenses relating to harvesting of the organ(s), as well as the costs of treating complications directly resulting from the procedure(s), are covered, provided the organ recipient is a member of the health plan, and provided the donor is not eligible for such coverage under any other health care plan or government-funded program.

Waiting period: Members must be enrolled in Basic Health for 12 consecutive months before they can receive benefits for transplant procedures. The waiting period applies to the transplant procedure including any immediate pre- and post-operative hospital care related to the transplantation, but does not apply to ongoing follow-up care including prescription drugs.

If a member satisfies the 12 consecutive month waiting period (no breaks in coverage for 12 consecutive months) and subsequently has a break in Basic Health coverage, full credit will be given toward the waiting period if the break in coverage is not longer than one month. A member may not have more than two such one-month breaks in coverage during a 12-month period for full credit to continue.

The waiting period will not apply:

1. If the transplant is required due to a condition which is not a pre-existing condition;
2. For children enrolled in and continuously covered by Basic Health from birth; or,
3. For children placed in the home for purposes of adoption within 60 days of birth and continuously covered by Basic Health from the date of placement, provided one or both of the adoptive parents or family members are enrolled in Basic Health at the time of placement in the home.

If a newborn child enrolled from birth, or a newborn-adoptive child enrolled within 60 days of placement, subsequently has a break in Basic Health coverage, full credit will be given toward the waiting period if the break in coverage is not longer than one month. A member may not have more than two such one-month breaks in coverage during a 12-month period for full credit to continue.

Limitations: Transplants that are not preauthorized or are not performed in a health plan-designated medical facility are not covered. No benefits are provided for charges related to locating a donor, such as tissue typing of family members.

All services are subject to the appropriate copayment at the time of service.

G. Emergency care

An emergency is a sudden or severe health problem that needs treatment right away; there is not time to talk to your doctor.

"Emergency" is defined as:

> "The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy."

The health plan reserves the right to determine whether or not the symptoms indicate a medical emergency. Acute detoxification is covered for up to 72 hours.

1. **In-service-area emergency**. In the event a member experiences a medical emergency, care should be obtained from a health plan-contracting provider. If, as a result of such emergency, the member is not able to use a health plan-contracting provider, the member may obtain such services from non-contracting health care providers. Follow-up care must be provided or approved by the health plan. In the case of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within twenty-four (24) hours of admission, or as soon thereafter as is reasonably possible. Failure to meet the notification requirements will result in coverage limited to what would have been payable by the health plan to a health plan-contracting provider had notification requirements been met. The member will be financially responsible for any remaining balance.

2. **Out-of-service-area emergency**. The health plan shall bear the cost of out-of-service-area emergency care for covered conditions. In the event of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within twenty-four (24) hours of admission, or as soon thereafter as is reasonably possible. Failure to meet the notification requirements will result in coverage limited to what would have been payable by the health plan to a health plan-contracting provider had notification requirements been met. The member will be financially responsible for any remaining balance.

   The health plan may, at its discretion, appoint a consultant when out-of-service-area care is necessary, who will have authority to monitor the care rendered and make recommendations regarding the treatment plan. The health plan may otherwise secure information which it deems necessary concerning the medical care and hospitalization provided to the member for which payment is requested.

3. **Transfer and follow-up care**. If a member is hospitalized in a non-contracting facility, the health plan reserves the right to require transfer of the member to a health plan-contracting facility, when the member's condition is sufficiently stable to enable safe transfer. If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

Follow-up care which is a direct result of the emergency must be obtained from a health plan-contracting provider, unless a health plan-contracting provider has authorized such care in advance.

4. **Prescription drugs.** Prescription drugs purchased from a non-contracting facility or pharmacy are covered subject to the applicable pharmacy copayment when dispensed or prescribed in connection with covered emergency treatment.

5. **Emergency ambulance transportation.** Medically necessary ambulance transportation is covered in an emergency, or to transfer a member when preauthorized by the health plan.

H. Skilled nursing and home health care benefits

As an alternative to hospitalization in an acute care facility, the health plan, at its discretion, may authorize benefits for the services of a skilled nursing facility or home health care agency.

I. Hospice services

Hospice services are covered.

J. Plastic and reconstructive services

Plastic and reconstructive services (including implants) will be provided:

1. To correct a physical functional disorder resulting from a congenital disease or anomaly;

2. To correct a physical functional disorder following an injury or incidental to covered surgery; and

3. For a member who is receiving benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses (internal and external) and physical complications of all stages of mastectomy.
- Treatment of lymphedemas is covered; however, durable medical equipment and supplies used to treat lymphedemas may be covered only in limited circumstances. Please contact your health plan for specific coverage information.

K. Preventive Care

Preventive care services are covered, and will be provided as described in the schedule provided to you by the health plan.

L. Pharmacy benefit

(Full-premium members: Please refer to page 25.)

The health plan may limit the drugs available through use of a list called a "formulary." Each health plan's formulary includes all major therapeutic classes of drugs. Drugs not in the formulary will be covered if the health plan's medical staff determine that no formulary drugs are an acceptable medication for the patient. If you have a question about the benefits listed, are not sure if a drug is covered, or believe a nonformulary drug should be covered, you should call the health plan's customer service department for information.

Basic Health covers drugs (of all types, including prescribed creams, ointments, and injections) at the copayment levels shown.

Prescriptions are limited to a 30-day supply.

Tier 1	Tier 2	Tier 3
Copayment: $3	**Copayment: $7**	**Copayment: 50%**
Covered Drugs: (Examples) Amoxicillin Clotrimazole vaginal cream Co-Trimoxazole Diphenhydramine Doxycycline Erythromycin base Erythromycin ethylsuccinate Insulin Metronidazole Nystatin (oral or topical) Permethrin Prenatal vitamins	Covered Drugs: Generic drugs contained in the health plan's formulary, except those included in Tier 1. All oral contraceptives in the health plan's formulary. Syringes and needles Diabetic test strips Lancets	Covered Drugs: Brand-name drugs in the health plan's formulary.

Drugs for cosmetic purposes are excluded unless preauthorized.

M. Additional services

Services in addition to those listed in this "Schedule of Benefits" may be provided by the health plan, at the sole discretion of the health plan, subject to copayments and limitations. You will not be required to accept these additional services as a condition of enrollment in Basic Health, or to pay any additional premium for such additional services.

III. Copayments

(Full-premium members: Refer to page 25.)

The member is responsible for paying any required copayment directly to the provider of a covered service unless instructed by the health plan to make payment to another party. Copayments must be paid in full at the time of service, or service may be denied or rescheduled.

Only those copayments specifically listed below are to be charged to members for covered services. Members may be charged a missed appointment fee by a provider if they continually fail to keep appointments, or if they repeatedly fail to give timely notice when it is necessary to cancel appointments.

Covered service	Your copayment
Physician	$10 per office or home visit; no copayment for maternity care.
Hospital	$100 per inpatient admission, $500 maximum per member per calendar year; no copayment for maternity care, or readmission for the same condition within 90 days.
Outpatient facility	
Non-emergency	$25 per non-emergency outpatient admission or facility visit; no copayment for maternity care, or readmission for the same condition within 90 days.
Emergency	$50; waived if an inpatient admission results.
Lab & x-ray	No copayment.
Ambulance	$50; no copayment when the health plan requires a member to transfer from a non-contracting facility to a contracting facility, or when transfer to and from a facility is required for the member to receive necessary services.
Preventive care	No copayment.
Maternity care	No copayment. If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered only through the Department of Social and Health Services.
Pharmacy (See "Pharmacy benefit" for types of drugs covered in each tier.)	Tier 1: $3 Tier 2: $7 Tier 3: 50%

IV. Limitations and exclusions

A. Limitations

1. Preexisting condition waiting period

(a) A preexisting condition is defined as: "Any illness, injury, or condition for which, in the six (6) months immediately preceding a member's effective date of enrollment in Basic Health:

- Treatment, consultation, or a diagnostic test was recommended for or received by the member, or
- Medication was prescribed or recommended for the member; or
- Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment."

(b) **Waiting period**

Basic Health will not provide benefits for services or supplies rendered for any preexisting condition during the first nine (9) consecutive months following the member's effective date of coverage. A member will not be required to begin a new nine (9) consecutive-month waiting period if:

- Coverage is suspended for not longer than one (1) month during the waiting period, and
- The member does not have more than two (2) one-month breaks in coverage during the waiting period.

Coverage for preexisting conditions will not be available until the member is actually covered by Basic Health for a total of nine (9) months.

If the member is confined in a health care facility for treatment of a preexisting condition at the time the member's nine (9) month waiting period ends, benefits for that condition will be provided only for covered services rendered after the end of the waiting period.

(c) **Exceptions to waiting period**

(i.) The following services are not subject to the waiting period:

- Maternity care.
- Prescription drugs as defined in "Pharmacy Benefit."

(ii.) Children born on or after the parent's and/or sibling's effective date of coverage who are enrolled within 60 days of the date of birth, and adopted children who are acquired after the adoptive parent's and/or sibling's effective date of coverage who are enrolled within 60 days of physical placement with the adoptive parents, are not subject to the nine (9) month waiting period for preexisting conditions.

(d) **Credit toward the waiting period**

Credit toward the waiting period will be given for:

- The length of delay in enrollment up to a maximum of three (3) months when, due to Basic Health budgetary constraints, enrollment is delayed for applicants who have otherwise completed the enrollment process and have been determined to be eligible for enrollment.

- Any continuous period of time for which a member was covered under similar health coverage if:

  - That coverage was in effect at any time during the three (3) month period immediately preceding the date of reservation or application for coverage under Basic Health, or within the three (3) month period immediately preceding enrollment in Basic Health; and

  - The coverage terminated not later than the first of the month following the effective date of coverage in Basic Health.

If similar coverage was in effect both prior to the date of application or reservation and the date of enrollment, credit will be given for the longer period of continuous coverage.

"Similar coverage" includes Basic Health; all DSHS programs administered by the Medical Assistance Administration which have the Medicaid scope of benefits; the DSHS program for the medically indigent; Indian Health Services; most coverages offered by health carriers; and most self-insured plans.

2. Major disaster or epidemic. If the health plan is prevented from performing any of its obligations hereunder in whole or part as a result of major epidemic, act of God, war, civil disturbance, court order, labor dispute, or any other cause beyond its control, the health plan shall make a good faith effort to perform such obligations through its then-existing and contracting providers and personnel. Upon the occurrence of any such event, if the health plan is unable to fulfill its obligations either directly or through contracting providers, it shall arrange for the provision of alternate and comparable performance.

3. The benefits available under Basic Health shall be secondary to the benefits payable under the terms of any health plan which provides benefits for a Basic Health member except where in conflict with Washington State or federal law.

B. Exclusions

The services listed below are not covered:

1. Services that do not meet coverage criteria for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions.

2. Services not provided, ordered, or authorized by the member's health plan or its contracting providers, except in an emergency.

3. Services received before the member's effective date of coverage.

4. Custodial or domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial

care is care that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.

5. Hospital charges for personal comfort items; or a private room unless authorized by the member's health plan; or services such as telephones, televisions, and guest trays.

6. Emergency facility services for nonemergency conditions.

7. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.

8. Transportation except as specified under "Organ transplants" and "Emergency care."

9. Implants, except: cardiac devices, artificial joints, intraocular lenses (limited to the first intraocular lens following cataract surgery), and implants as defined in the "Plastic and reconstructive services" benefit.

10. Sex change operations; investigation of or treatment for infertility or impotence; reversal of sterilization; artificial insemination; and in vitro fertilization.

11. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery); routine eye examinations, including eye refraction, except when provided as part of a routine examination under "Preventive care;" and hearing aids.

12. Orthopedic shoes and routine foot care.

13. Speech and occupational therapy.

14. Medical equipment and supplies not specifically listed in this "Schedule of Benefits" (including but not limited to hospital beds, wheelchairs, walk aids, respiratory equipment, and oxygen) except:

    a) While the member is in the hospital, or

    b) When a provider contracted with the member's health plan requests prior approval of a service, supply, or equipment. The health plan may limit approval to those situations where, in its sole judgment, it is expected that coverage will result in a lower, total out-of-pocket cost to the health plan if the member were to stay in Basic Health and the health plan for a subsequent four (4) years.

15. Dental services, including orthodontic appliances, and services for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that such repair begins within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, provided the member is eligible for covered services at the time that services are provided.

16. Obesity treatment; weight loss programs.

17. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in this "Schedule of Benefits."

18. Medical services received from or paid for by the Veterans Administration or by state or local government, except where in conflict with the Revised Code of Washington or federal law; the portion of expenses for medical services payable under the terms of any insurance policy that provides payment toward the member's medical expenses without a determination of liability to the extent that payment would result in double recovery.

19. Conditions resulting from acts of war (declared or not).

20. Direct complications arising from excluded services.

21. Any service or supply not specifically listed as a covered service, unless prescribed by a contracting provider and authorized by the health plan.

C. Changes to covered services and premiums

The Basic Health Administrator may from time to time revise this "Schedule of Benefits." In designing and revising this "Schedule of Benefits," the Administrator will consider the effects of particular benefits, copayments, limitations and exclusions on access to necessary basic health care services, as well as the cost to members and to the state, and will also consider generally accepted practices of the health insurance and managed health care industries.

The HCA will provide you with written notice of any planned revisions to Basic Health premiums or the benefit plan at least 30 days prior to the effective date of the change. This notice may be included with your premium statement, open enrollment materials or other mailing, or may be a separate notice. For purposes of this provision, notice shall be deemed complete upon depositing the written revisions in the United States mail, first-class postage paid, directed to you at the mailing address on file with the HCA.

APPENDIX B:
Schedule of Benefits for Basic Health *Plus* and Maternity Benefits Program

Note: In this portion of the document, the "Contractor" is your health plan. The "Department" refers to the Washington State Department of Social and Health Services.

I. Covered Services:

A. The Contractor shall cover the services described in this Section when medically necessary. The amount and duration of covered services that are medically necessary depends on the enrollee's condition.

B. Except as specifically provided herein, the scope of covered services shall be comparable to the Medical Assistance Administration's (MAA) Medicaid fee-for-service program. For specific covered services, this shall not be construed as requiring the Contractor to cover the specific items covered by MAA under its fee-for-service program, but shall rather be construed to require the Contractor to cover the same scope of services.

C. Enrollees have the right to self-refer for certain services to providers paid through separate arrangements with the State of Washington. The Contractor is not responsible for the coverage of the services provided through such separate arrangements. The enrollees also may choose to receive such services from the Contractor. The Contractor shall assure that enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the enrollee's choice of where to receive the services. If the Contractor in any manner deprives enrollees of their free choice to receive services through the Contractor, the Contractor shall pay the local health department, family planning facility, or Regional Support Network (RSN) for such services up to the limits described herein. The services to which an enrollee may self-refer are:

1. Outpatient mental health services to community mental health providers of the Regional Support Network (RSN) for Prepaid Health Plan.
2. Family planning services and sexually-transmitted disease screening and treatment services provided at family planning facilities, such as Planned Parenthood.
3. Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through the local health department.
4. Medical services provided to enrollees who have a diagnosis of alcohol and/or chemical dependency are covered when those services are otherwise covered services.

D. Inpatient Services:
Provided by acute care hospitals (licensed under RCW 70.41), or nursing facilities (licensed under RCW 18-51) when nursing facility services are not covered by the Department's Aging and Adult Services Administration and the Contractor determines that nursing facility care is more appropriate than acute hospital care. Inpatient physical rehabilitation services are included.

E. Outpatient Hospital Services:
Provided by acute care hospitals (licensed under RCW 70.41).

F. Emergency Services: All inpatient and outpatient services that are provided by a provider who is qualified to furnish Medicaid services, without regard to whether the provider is a participating or non-participating provider, which are necessary to evaluate and stabilize an emergency medical condition.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 USC 1396u-2(b)(2)(c)).

Emergency services shall be provided without requiring prior authorization.

Services provided when the PCP or other plan representative has instructed the enrollee to seek emergency services, regardless of whether the enrollee's condition meets the prudent layperson standard.

If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor.

Any post-stabilization services, related to the admitting diagnosis, up to the point of discharge, that the Contractor has either:

1. Authorized
2. Failed to authorize because the Contractor did not respond within thirty (30) minutes to a request for authorization for post-stabilization services (RCW 48.43.093(d))
3. Failed to authorize due to circumstances beyond the emergency department's control

G. Ambulatory Surgery Center:
Services provided at ambulatory surgery centers.

H. Provider Services:
Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, midwives, podiatrists, audiologists, registered nurses, and certified dietitians.

Provider Services include, but are not limited to:

- Medical examinations, including wellness exams for adults and Early Periodic Screening and Diagnostic Testing (EPSDT) for children
- Immunizations
- Maternity care
- Family planning services provided or referred by a participating provider or practitioner
- Performing and/or reading diagnostic tests
- Private duty nursing
- Surgical services
- Surgery to correct defects from birth, illness, or trauma, or for mastectomy reconstruction
- Anesthesia
- Administering pharmaceutical products
- Fitting prosthetic and orthotic devices
- Rehabilitation services
- Enrollee health education

- Nutritional counseling for specific conditions such as diabetes, high blood pressure, and anemia
- Nutritional counseling when referred as a result of an EPSDT exam

I. Tissue and Organ Transplants:
Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, and peripheral blood stem cell.

J. Laboratory, Radiology, and Other Medical Imaging Services:
Screening and diagnostic services and radiation therapy.

K. Vision Care:
Eye examinations for visual acuity and refraction once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21). These limitations do not apply to additional services needed for medical conditions. The Contractor may restrict non-emergent care to participating providers. Enrollees may self-refer to participating providers for these services.

L. Outpatient Mental Health:

1. Psychiatric and psychological testing, evaluation and diagnosis:
   a. Once every twelve (12) months for adults twenty-one (21) and over
   b. Unlimited for children under age twenty-one (21) when identified in an EPSDT visit
2. Unlimited medication management:
   a. Provided by the PCP or by PCP referral
   b. Provided in conjunction with mental health treatment covered by the Contractor
3. Twelve hours per calendar year for treatment
4. Transition to the RSN, as needed to assure continuity of care, when the enrollee has exhausted the benefit covered by the Contractor or when enrollee request such transition
5. Referrals To and From the RSN:
   a. The Contractor shall cover mental health services provided by the RSN, up to the limits described herein, if the Contractor refers an enrollee to the RSN for those services.
   b. The Contractor may, but is not required to, accept referrals from the RSN for the mental health services described herein.
6. The Contractor may subcontract with RSNs to provide the outpatient mental health services that are the responsibility of the Contractor. Such agreements shall not be written or construed in a manner that provides less than the services otherwise described in this Section as the Contractor's responsibility for outpatient mental health services.
7. The DSHS Mental Health Division (MHD) and MAA shall each appoint a Mental Health Care Coordinator (MHCC). The MHCCs shall be empowered to decide all Contractor and RSN issues regarding outpatient mental health coverage that cannot be otherwise resolved between the Contractor and the RSN. The MHCCs will also undertake training and technical assistance activities that further coordination of care between MAA, MHD, Healthy Options contractors and RSNs. The Contractor shall cooperate with the activities of the MHCCs.

M. Occupational Therapy, Speech Therapy, and Physical Therapy:
Services for the restoration or maintenance of a function affected by a enrollee's illness,

disability, condition or injury, or for the amelioration of the effects of a developmental disability.

N. Pharmaceutical Products:
Prescription drug products according to a Department approved formulary, which includes both legend and over-the-counter (OTC) products. The Contractor's formulary shall include all therapeutic classes in MAA's fee-for-service drug file and a sufficient variety of drugs in each therapeutic class to meet medically necessary health needs. The Contractor shall provide participating pharmacies and participating providers with its formulary and information about how to request non-formulary drugs. The Contractor shall approve or deny all requests for non-formulary drugs by the business day following the day of request.

Covered drug products shall include:

1. Oral, enteral and parenteral nutritional supplements and supplies, including prescribed infant formulas
2. All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies; including but not limited to Depo-Provera, Norplant, and OTC products
3. Antigens and allergens
4. Therapeutic vitamins and iron prescribed for prenatal and postnatal care.

O. Home Health Services:
Home health services through Medicare-certified, state-licensed agencies.

P. Durable Medical Equipment (DME) and Supplies:
Including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for enrollees over three (3) years or age; and medical supplies.

Q. Oxygen and Respiratory Services:
Oxygen, and respiratory therapy equipment and supplies.

R. Hospice Services:
When the enrollee elects hospice care.

S. Blood, Blood Components and Human Blood Products:
Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products the Contractor shall cover the cost of the blood or blood products.

T. Treatment for Renal Failure:
Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

U. Ambulance Transportation:
The Contractor shall cover ground and air ambulance transportation for emergency medical conditions, as defined in Section F, Emergency Services, including, but not limited to, Basic and Advanced Life Support Services, and other required transportation costs, such as tolls and fares. In addition, the Contractor shall cover ambulance services under two circumstances for non-emergencies:

1. When it is necessary to transport an enrollee between facilities to receive a covered services; and,
2. When it is necessary to transport an enrollee, who must be carried on a stretcher, or who may require medical attention en route (RCW 18.73.180) to receive a covered service.

V. Chiropractic Services:
For children when they are referred during an EPSDT exam.

W. Neurodevelopmental Services:
When provided by a facility that is not a DSHS recognized neurodevelopmental center.

X. Smoking Cessation Services:
For pregnant women through sixty (60) days post pregnancy.

II. Exclusions:

The following services and supplies are excluded from coverage. This shall not be construed to prevent the Contractor from covering any of these services when the Contractor determines it is medically necessary.

A. Services Covered By MAA Fee-For-Service Or Through Selective Contracts:

- School Medical Services for Special Students as described in the MAA billing instructions for School Medical Services.
- Eyeglass Frames, Lenses, and Fabrication Services covered under DSHS' selective contract for these services, and associated fitting and dispensing services.
- Voluntary Termination of Pregnancy, including complications.
- Transportation Services other than Ambulance: Taxi, cabulance, voluntary transportation, public transportation.
- Dental Care, Prostheses and Oral Surgery, including physical exams required prior to hospital admissions for oral surgery.
- Hearing Aid Devices, including fitting, follow-up care and repair.
- First Steps Maternity Case Management and Maternity Support Services.
- Sterilizations for enrollees under age 21, or those that do not meet other federal requirements.
- Health care services provided by a neurodevelopmental center recognized by DSHS.
- Certain services provided by a health department or family planning clinic when a client self-refers for care.
- Inpatient psychiatric professional services.
- Pharmaceutical products prescribed by any provider related to services provided under a separate agreement with DSHS or related to services not covered by the Contractor.
- Laboratory services required for medication management of drugs prescribed by community mental health providers whose services are purchased by the Mental Health Division.
- Protease Inhibitors
- Services ordered as a result of an EPSDT exam that are not otherwise covered services.
- Gastroplasty
- Prenatal Diagnosis Genetic Counseling provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing. Genetic services beyond Prenatal Diagnosis Genetic Counseling are covered as maternity care when medically necessary, see Section H, Provider Services.
- Gender dysphoria surgery and related procedures, treatment, prosthetics, or supplies when approved by DSHS in accord with WAC 388-531.

B. Services Covered By Other Divisions In The Department Of Social And Health Services:

- Substance abuse treatment services covered through the Division of Alcohol and Substance Abuse (DASA), including

inpatient detoxification services for alcohol (3-day) and drugs (5-day) with no complicating medical conditions.

- Nursing facility and community based services (e.g. COPES and Personal Care Services) covered through the Aging and Adult Services Administration.
- Mental health services separately purchased for all Medicaid clients by the Mental Health Division, including 24-hour crisis intervention, outpatient mental health treatment services, and inpatient psychiatric services. This shall not be construed to prevent the Contractor from purchasing covered outpatient mental health services from community mental health providers.
- Health care services covered through the Division of Developmental Disabilities for institutionalized clients.

C. Service Covered By Other State Agencies:

Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health. Medically necessary nutritional supplements for infants are covered under the pharmacy benefit.

D. Services Not Covered by Either DSHS or the Contractor:

- Medical examinations for Social Security Disability.
- Services for which plastic surgery or other services are indicated primarily for cosmetic reasons.
- Physical examinations required for obtaining continuing employment, insurance or governmental licensing.
- Experimental and Investigational Treatment or Services, services associated with experimental or investigational treatment or services.

  The policies and prodecures and any criteria the contractor uses to determine that a service is experimental or investigational, will be provided to you, by your contractor, at your request.
- Reversal of voluntary surgically induced sterilization.
- Personal Comfort Items, including but not limited to guest trays, television and telephone charges.
- Biofeedback Therapy.
- Diagnosis and treatment of infertility, impotence, and sexual dysfunction.
- Orthoptic (eye training) care for eye conditions.
- Tissue or organ transplants that are not specifically listed as covered.
- Immunizations required for international travel purposes only.
- Court-ordered services.
- Any service provided to an incarcerated enrollee, beginning when a law enforcement officer takes the enrollee into legal custody.
- Any service, product, or supply paid for by MAA under its fee-for-service program only on an exception to policy basis. The Contractor may also make exceptions and pay for services it is not required to cover under this agreement.
- Any other service, product, or supply not covered by MAA under its fee-for-service program.

APPENDIX C:
A Guide to Terms Used in This Handbook

BASIC HEALTH
A health coverage program administered by the Health Care Authority (HCA).

BASIC HEALTH *PLUS*
A Medicaid program jointly administered with the Department of Social and Health Services (DSHS) Medical Assistance Administration for children under age 19 from low-income families. It provides expanded benefits (such as dental and vision care) and has no premiums or copayments. Eligibility for Basic Health *Plus* is determined by DSHS, based on Medicaid eligibility criteria.

CERTIFICATE OF COVERAGE
A description of your health care coverage and benefits. This handbook serves as your certificate of coverage.

CONTRACTOR
In Appendix B, refers to the health plan that provides Basic Health *Plus* or Maternity Benefits Program coverage.

COPAYMENT
The portion of an expense you pay when you receive care.

DSHS
Department of Social and Health Services. The state agency which administers Medicaid and (along with the Health Care Authority) jointly administers Basic Health *Plus* and the Maternity Benefits Program.

DEPENDENT
Same as family members.

DISENROLLMENT (FOR NONPAYMENT)
The process of losing Basic Health coverage due to nonpayment by the due date given in the notice of suspension or because of more than two suspensions in a 12-month period.

ENROLLMENT
The process of submitting completed application forms, being determined eligible, and being accepted into Basic Health, Basic Health *Plus*, or the Maternity Benefits Program.

FAMILY MEMBERS
Family members who should be listed as dependents on your account include your:

- Spouse (unless legally separated)
- Your or your spouse's unmarried children, whether by birth, adoption, legal guardianship, or placement pending adoption, who are:
  - Under age 19; or
  - Under age 23, if full-time students at an accredited school.
- Legal dependent, of any age, who is incapable of self-support due to disability.

FIRST STEPS
Medicaid coverage designed to reduce maternal and infant illness and death, as well as increase access to maternity and infant care. Pregnant women eligible for DSHS medical assistance are eligible to receive First Steps services.

FORMULARY
An approved list of prescription drugs developed by each health plan.

Full-premium program
Basic Health's health coverage program in which members pay the full cost of their monthly premium, based on the Health Care Authority's contracted rates with managed care plans.

Health Care Authority (HCA)
The state agency responsible for Basic Health administration and coordinating with DSHS to provide Basic Health *Plus* and the Maternity Benefits Program.

Health plan
An organization that offers health care coverage and contracts with the HCA to provide your care. You choose your health plan when you join Basic Health. Appendix B refers to the health plan as the "Contractor."

Income
Your wages and salaries; tips; interest; dividends; royalties; public or private pensions; social security benefits; Labor & Industries (L&I) and Department of Social and Health Services (DSHS) grants; child support; unemployment compensation; net income from rentals or self-employment; and any other income as defined by Basic Health.

Income band
Income levels A through H, as listed in the *How Much Will Basic Health Coverage Cost?* brochure. These levels, based on gross monthly income and family size, help determine monthly premiums.

Income guidelines
The guidelines used to determine your eligibility for Basic Health and Basic Health *Plus*, and your monthly premium payments for Basic Health coverage. These income guidelines change annually. Refer to the *How Much Will Basic Health Coverage Cost?* brochure for more information.

Inpatient
A patient who is admitted for an overnight or longer stay at a health care facility and is receiving covered services.

Maternity Benefits Program
The program coordinated with DSHS for eligible pregnant women. This program includes all Medicaid benefits, including maternity benefits, maternity support services, and maternity case management. Eligibility for the program is determined by the DSHS Medical Assistance Administration, based on Medicaid eligibility criteria.

Medicaid
The federal aid program which provides medical coverage for persons in the DSHS categorically needy and medically needy programs.

Medical Assistance Administration (MAA)
A unit of DSHS that is authorized to administer medical care. MAA and Basic Health jointly administer Basic Health *Plus* and the Maternity Benefits Program.

Medicare
The federal health benefit program for people who are ages 65 and over, and for some people with disabilities. (If you are eligible for free or purchased Medicare coverage, you are not eligible for Basic Health.)

Member
A person enrolled in Basic Health, Basic Health *Plus*, or the Maternity Benefits Program, and receiving coverage.

Outpatient
A nonhospitalized patient receiving covered services away from a hospital such as in a physician's office or the patient's own home, or in a hospital outpatient or hospital emergency department.

Personal eligibility statement (PES)
The notice Basic Health sends you, showing the current status of your account. **You will receive a PES each time there is a change to your account.** This statement may include a bill for additional premiums you must pay as a result of a change.

Physician Incentive Plan (PIP)
Any conpensation arrangement between a Medicaid contractor and a physician or physican group that may directly or indirectly have the effect of reducing or limiting services to enrollees under the terms of the Medicaid contract

Premium
Your monthly payment for Basic Health coverage.

Premium "lock-in"
The period of time for which a member's premium will not change, unless the member has a qualifying change of circumstances (such as a job change, marriage, or divorce) or all Basic Health premiums change (such as with a new contract year). Premiums are "locked in" when a member's income has been calculated using income averaging.

Primary care provider (PCP)
Your personal provider. Your primary care provider can be a family or general practitioner, internist, pediatrician, or other provider approved by your health plan. To receive benefits, your primary care provider must provide or coordinate your care. If you need to see a specialist, your primary care provider will refer you.

Provider
A health care professional (such as a doctor, nurse, internist, etc.) or facility (such as a hospital, clinic, etc.).

Recertification
Periodic review of members' income and eligibility. During recertification, members are required to submit current income and residency documentation to verify their eligibility and/or level of premium subsidy.

Recoupment
When Basic Health bills a member for any premium subsidy overpaid because the member failed to accurately report income or income changes.

Reduced-premium program
Basic Health's health coverage program that offers members a lower-cost monthly premium, with the state paying a share of the monthly premium. The member's income must be less than the Basic Health income guidelines (based on their family size) to be eligible for the reduced-premium program.

Service area
The geographic area served by a health plan that is providing coverage for Basic Health members.

Specialist
A provider of specialized medicine, such as a cardiologist or a neurosurgeon.

Student
A person enrolled full-time in an accredited secondary school, college, university, technical college, or school of nursing, as determined by the school registrar.

Subscriber
The person on a Basic Health account who is responsible for payment of premiums and copayments and to whom Basic Health sends all notices and communications. The subscriber may be a Basic Health member or the spouse, parent, or legal guardian of an enrolled dependent.

Suspension of coverage (for nonpayment)
The process of losing health coverage for a period of one month after a monthly premium has not been paid or has been paid after the due date. If your coverage is suspended more than two times in a 12-month period, you will be disenrolled and cannot re-enroll for at least 12 months.

Tier
A category of drugs related to the pharmacy benefit. Your cost for prescriptions depends on the category (or tier) the prescription falls within. (For example, Tier 1 is in the category of prescriptions that costs you the least.)

Washington resident
A person physically residing and maintaining an abode in the state of Washington.

Income Worksheets

- Monthly Income Worksheet
- Self-Employment/Rental Income Worksheet

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MONTHLY INCOME WORKSHEET

Follow the instructions beginning on page 3. If you have rental or self-employment income, you may also be required to fill out the *Self-Employment/Rental Income Worksheet* on the other side of this form.

❑ Check here if you want your monthly Basic Health premium based on the most recent three consecutive months' income. Be sure to attach proof of each source of income for all three months. Read page 3 of the instructions.

Do not send original documents. They cannot be returned to you.

Income source	Income received	Family member who received this income:	Send a copy of:
Wages, salary, commissions, or tips for the most recent 30 days or full calendar month	$		Pay stubs. (If your pay stub does not show the amount you received as tips, include a signed and dated statement from your employer, indicating the amount you earned in tips.)
Self-employment or rental profit or loss, if applicable (from your IRS Form 1040 or line 32 of the *Self-Employment/Rental Income Worksheet*) UBI number:	$		Your most recently filed federal income tax return (IRS Form 1040) and all applicable schedules. (If you were not required to file a tax return or are asking us to use less than 12 months of information, complete and send the *Self-Employment/Rental Income Worksheet*.)
Unemployment compensation	$		Check stubs.
L&I (workers' compensation)	$		Award letter showing your current gross monthly benefits.
Child support, family support, alimony	$		◗ Checks; ◗ Court documents indicating the amount awarded; ***or*** ◗ Office of Support Enforcement (DSHS) statement.
Social security or supplemental security income	$		Benefits statement received at the beginning of the current year.
Public assistance (includes DSHS grants)	$		Copy of the award letter showing your monthly benefit and dates received.
Retirement income or pension	$		◗ Pay stub; ***or*** ◗ Award letter or benefit statement showing your current monthly benefit. ◗ Military cost of living allotment statement.
Other (please describe; see instructions with this application)	$		Read the instructions to find out what to send.
Subtotal:	$		
Subtract work-related dependent care expenses (see instructions):	—$		Receipts, canceled checks, or credit card invoices for work-related dependent care expenses, or the child support order showing the amount for child care expenses and the canceled check covering the most recent month. Include the name, address, and phone number of the dependent care provider.
Total gross monthly income:	$		IRS Form 1040 and schedules, or transcript or proof of nonfiling status (see the instructions).

If you or your spouse are reporting no income, you must briefly state how you supported yourself and then sign below.

Signature	Name (please print or type)	Date
		/ /
Signature of spouse	Name (please print or type)	Date
		/ /

HCA 24-301 (10/00)

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SELF-EMPLOYMENT/RENTAL INCOME WORKSHEET

Not everyone is required to complete this section. Read page 5 of the instructions to see if you need to fill in this information.

1 Check one: ❑ Self-employment income ❑ Rental income

2 Business name		3 UBI number
4 Business address	City State ZIP Code	
5 Type of business		6 Taxpayer I.D. or social security number

7 Indicate the months you are reporting on this form: MO / YR – MO / YR	**COLUMN I** Total for most recent 30 days or full calendar month (must be completed for Basic Health *Plus* or Maternity Benefits Program)	**COLUMN II** Total for period you are reporting	**COLUMN III** Average per month
INCOME			**A**
8 Gross receipts, sales, or rental income	$	$	$
EXPENSES			
9 Merchandise and materials	$	$	$
10 Gross wages paid to employees	$	$	$
11 Employer's payroll-related taxes	$	$	$
12 Advertising/other promotional expenses	$	$	$
13 Car and truck expenses	$	$	$
14 Commissions/management fees	$	$	$
15 Depreciation	$	$	$
16 Insurance	$	$	$
17 Interest – mortgage	$	$	$
18 Interest – other	$	$	$
19 Legal and professional services	$	$	$
20 Rent or lease – vehicles, machinery, or equipment	$	$	$
21 Rent or lease – other business property	$	$	$
22 Repairs and maintenance	$	$	$
23 Supplies	$	$	$
24 Taxes	$	$	$
25 Travel	$	$	$
26 Meals and entertainment	$	$	$
27 Utilities	$	$	$
28 Other expenses	$	$	$

29 **Total average monthly expenses** *Add expense totals from lines 9 through 28 in column III, and enter in B.*	— $ **B**
30 **Average monthly self-employment profit (or loss)** *Subtract B from A, and record in C.*	$ **C**
31 **Your share of profit (or loss)** Form of business: ❑ Sole proprietorship ❑ Partnership ❑ S-Corporation	Percentage of business you own % **D**
32 Your share of average monthly self-employment/rental profit (or loss) *Multiply C by D and record here and on the Monthly Income Worksheet under "self-employment or rental profit or loss."*	$

Monthly Income Worksheet Instructions

Fill out this section to report all gross family income, from all sources, before taxes. Gross family income includes all income received by you and any listed dependents, regardless of whether they're enrolled in Basic Health.

General Instructions – Monthly Income Worksheet

For each line, show all your household's gross income received during the last 30 consecutive days or complete calendar month and fill in the name of the person who received that income. Enter the actual dollar amount (rounded to the nearest dollar), or "0" on each line.

If you or a dependent received several months' income during a single month, you may divide that income by the number of months for which the income was received. Example: You receive a $5,000 check from the Social Security Administration in October to cover your disability benefits for the months of June through October (5 months). Your monthly income from that source is $1,000 ($5,000 ÷ 5 = $1,000 per month).

Attach the documentation listed under the "Send a copy of:" column. **Do not send original documents; they cannot be returned to you.** All income documentation must show the date the income was received, the period for which it was earned, and the recipient's name and/or social security number. If you cannot obtain the required income documentation, send a signed, dated statement that includes the name of the person paid, the payment dates, the income source, and the payment amount before taxes or other deductions.

In addition to the documentation listed under the "Send a copy of:" column, attach a signed copy of your most recently filed federal income tax return (IRS Form 1040 and all attachments you filed with it). Whether you filed by mail or electronically, you must have signed the IRS form (your tax preparer's signature is not sufficient). If you didn't have to file or don't have a copy of your tax return for the most recent year, attach a transcript of your account or verification of nonfiling status. You can request these from the IRS by calling 1-800-829-1040 or by taking form 4506 to your local IRS office.

Line-by-Line Instructions – Monthly Income Worksheet

Income Averaging ("Check here if you want...")

If your income changes enough from month to month to change your premium (generally, about $200 a month), you may want to check this box to request that your last three months' income be averaged. **If you are applying for Basic Health *Plus* or the Maternity Benefits Program, DSHS will determine eligibility using income documentation for the most recent month only.** If your income is averaged, your premium will not change for six months unless all Basic Health premiums change or your individual circumstances change (for example, you lose your job or your family size changes).

Wages, salary, commissions, tips

Fill in the amount for each adult family member. Do not include earned income for children.

Self-employment or rental profit or loss

Fill in the net profit or loss from self-employment or rental income. Use the amount shown on your federal income tax return, unless you are completing the *Self-Employment/Rental Income Worksheet* (see instructions for that section to find out if you need to complete it). If you complete the *Self-Employment/Rental Income Worksheet*, transfer the amount from line 32 of that section to the second line of this worksheet. Be sure to attach a signed copy of your IRS Form 1040 for the most recent year, including all schedules you filed, unless you weren't required to file. Fill in your Unified Business Identifier (UBI) number, from your Washington Master License.

Unemployment compensation

If you recently lost your job and received unemployment compensation, indicate the amount actually received within the most recent 30 days or calendar month. If this will not accurately reflect your income, send updated income documentation after you are enrolled.

L&I (workers' compensation)

Fill in the monthly amount you were awarded, before any deductions.

Child support, family support, alimony

Do not include payments from the Department of Social and Health Services (DSHS) adoption support program.

Social security or supplemental security income (SSI)

Fill in the monthly amount you were awarded, before any deductions.

Public assistance (includes DSHS grants)

This includes any financial assistance you receive from DSHS or other public assistance, other than adoption support.

Retirement income or pension

If you are reporting an IRA distribution, only show the amount of interest received.

Other
The table on the right shows the most common income sources that may be included here and the documentation to send for each of them.

Subtotal
Add all the figures in the column.

Work-related dependent care expenses
Fill in the total you paid to care for children 12 or younger or for a disabled adult dependent. This is also for the last 30 days or most recent calendar month (limited to $650 a month per dependent for work-related child care). For a disabled adult dependent, be sure to include proof of legal guardianship.

Total gross monthly income
Subtract work-related dependent care expenses from total and fill in that amount here.

"Other" Income	Send a copy of (do not send original documents)
Income from an adult foster home	◗ Your adult foster home license; ◗ Your most recently filed federal tax return (IRS Form 1040) and all applicable schedules; *and* ◗ Social Services Payment System (SSPS) Invoice Voucher. (If you were not required to file a federal income tax form, send the *Self-Employment/ Rental Income Worksheet* completed with your income and expenses for the most recent year.)
Personal care worker wages	Social Service Payment System (SSPS) Service Invoice Voucher.
Stipends or work study	◗ Pay stubs; or ◗ The award letter you received that states what you were paid and for how long.
Annuities	The monthly or quarterly statement from the institution that pays you.
Dividend income	Your statement from the bank or investment firm showing the amount of dividends for the most recent quarter or month.
Estates	Court documents.
Gambling or lottery winnings	Checks.
Insurance (such as life or long-term disability insurance)	The award letter or court documents showing the schedule of payments.
Interest income	Your statement from the bank or investment firm showing the amount of interest for the most recent quarter or month.
Military family allotments	Your Leave and Earning Statement (LES).
Royalties	◗ Checks; or ◗ Contract showing the amount you are paid.
Strike benefits	◗ Check stub showing dates paid and the gross amount paid; or ◗ Signed, dated statement from your union showing the amount paid, before any deductions.
Trusts	Legal trust documents.
Veteran's benefits	Award letter showing your current gross monthly benefits.
Income you cannot otherwise document	Signed and dated statement that includes your name, the date you were paid, the amount you were paid (before any deductions), and the name of the company or person who paid you.

Self-Employment/ Rental Income Worksheet Instructions

Complete this worksheet only if you had self-employment or rental income and:

- You are applying for **Basic Health *Plus* or the Maternity Benefits Program** for a family member (DSHS requires the information in column I for the most recent full calendar month);
- You were **not required to file** a federal income tax return; or
- You are **reporting less than 12 months** of income and expenses (see second paragraph under "General Instructions," below).

Otherwise, you do not need to fill out this worksheet; we will use your IRS Form 1040 and schedules to document your self-employment or rental income. Be sure to include copies of all the schedules you filed, especially schedules A - E, F, K1, and 8582 if they apply to you. Because your current profit (or loss) may have changed since the amount reported on your IRS Form 1040, you may send updated income and expense documentation (such as quarterly tax statements or monthly year-to-date profit/loss statements).

General Instructions – Self-Employment/Rental Income Worksheet

For each line and column, fill in the appropriate dollar amount or "0."

Twelve months of income and expense history are required to determine average monthly profit (or loss). If you have owned the business or rental property for a shorter time, attach a written statement of how long you've owned the business or rental property. Then fill in current monthly income and expenses for the actual number of months you are reporting on this worksheet.

Income history from the *previous* tax year must be based on your IRS Form 1040 (if filing was required) or on historical monthly income and expense documentation.

Income history for the *current* tax year must be based on current income and expense documentation.

All expenses must be related to your business or your rental property. Other expenditures cannot be deducted from your gross family income as expenses.

Column I

Fill in the total for the most recent full calendar month. This is necessary only if you are applying for Basic Health *Plus* or the Maternity Benefits Program for a family member.

Column II

Fill in the total for the number of months you are reporting for the income and expense categories listed.

Column III

Divide the total from column II by the number of months you are reporting to get the average monthly income or expense. Fill in the average.

Line-by-Line Instructions – Self-Employment/Rental Income Worksheet

Line 1

Check the box next to the type of income you're reporting. To report income for more than one type of business or rental, please use separate forms.

Line 2

Write in your name or the name of your business.

Line 3

Fill in your Unified Business Identifier (UBI) number, assigned by the Washington State License Service.

Line 4

Fill in the address of your business. If your business is operated from your home, list your residential address.

Line 5

Include a brief description of the type of business (like gas station, day care, etc.).

Line 6

Fill in your federal taxpayer I.D. number. This is generally your social security number, unless your business is a partnership or a corporation.

Line 7

Fill in the actual months for which you are reporting income and expenses.

Line 8

Fill in the gross income receipts or sales for your business or rental income before any deductions.

Line 9

Fill in the cost of goods sold, including the purchase price of raw materials, shipping, and storage.

Line 10

Do not include payments to yourself, your spouse, or partner(s).

Line 11

Include OASI (social security), Medicare, L&I (workers' compensation), and UI (unemployment insurance) taxes and charges.

Line 12

Fill in your total business or rental advertising or other promotional expenses.

Line 13

Fill in your total car or truck expenses for business-related travel. You may use the actual expense if you have proof that you spent that amount, or the standard mileage rate (36.5 cents per mile for 2000).

Line 14

Fill in your total business or rental commissions, or management fees paid to others.

Line 15
Fill in your annual business or rental depreciation/amortization amount. If you were not required to file an IRS Form 1040, estimate the number of years the equipment/building will be useful. Divide the purchase price by this number of years to determine annual depreciation.

Line 16
Fill in only the costs of insurance directly related to your business or rental activity, such as liability and property insurance. Do not include vehicle insurance costs separately if you used the standard mileage allowance for car and truck expenses (see line 13).

Line 17
Fill in the interest paid on real property mortgages used for your business. *Do not* include amounts paid as repayment of principal. If you use only part of your home (or other property) for business, you must determine the "business percentage" of these expenses. Generally, the business percentage for mortgage interest is the same as the percentage of the property used for business (see line 21).

Line 18
Fill in the interest paid on business-related loans *other than* mortgages. *Do not* include amounts paid as repayment of principal.

Line 19
Fill in your total business- or rental-related legal and professional expenses, such as attorney, accountant, and appraiser fees.

Line 20
Fill in your business- or rental-related expenses for rent or lease of vehicles, machinery, or equipment.

Line 21
Fill in the business- or rental-related expenses for rent or lease of other business property. If the entire property is not used exclusively for business, measure the area of the property in square feet and calculate this by dividing the area of the property used for business by the total area of the property, including the basement. Example: Your property measures 1,200 square feet. You use one room that measures 240 square feet for business. Therefore, you use one-fifth (240 ÷ 1,200), or 20%, of the total area for business.

Line 22
Fill in the business- or rental-related expenses for routine repair and maintenance of your business, equipment, vehicle(s), or rental property. *Do not* include payments for your own labor, or car- and truck-related expenses from line 13.

Line 23
Fill in your business- or rental-related expenses for supplies, such as office supplies, postage, shipping, and handling for your business.

Line 24
Fill in your business- or rental-related *non*payroll taxes, such as property taxes, business and occupational taxes, and business-related license fees. You may list half of the self-employment tax you paid.

Line 25
Fill in business-related travel expenses, which are ordinary and necessary expenses incurred while traveling for your business or profession. *Do not* include expenses listed in line 13.

Line 26
Fill in your business-related expenses for meals and entertainment.

Line 27
Fill in business-related expenses for utilities such as heat, lights, power, and telephone service. List only utility expenses used to support your business. If you use only part of your home (or other property) for business, determine the business percentage of these expenses, generally the same as the percentage of property used for business (see line 21). Example: your electric bill is $400 for lighting, cooking, laundry, and television. Only the lighting bill is used for business. If $250 of your electric bill is for lighting and you use 10% of your property for business, then $25 is considered a business-related expense.

Line 28
Fill in other related business expenses that you will file with your tax return and describe them briefly.

Calculations

Line 29
Add the figures in column III, lines 9 through 28, to determine your total average monthly expenses. Write this amount in box B.

Line 30
Subtract the amount in box B from the amount in box A (at the top of column III) to determine your average monthly self-employment profit (or loss) amount. Write this amount in box C.

Line 31
Check the box next to the appropriate form of business. Determine the percentage of business that you own and write that percentage in box D. If you and your spouse are both partners in the business, this would be the sum of your ownership percentages. Use 100% for a sole proprietorship.

Line 32
Multiply the amount in box C by the percentage in box D to determine your share of the average monthly self-employment/rental net profit (or loss). Transfer this amount to the Monthly Income Worksheet, in the box for "Self-employment or rental profit or loss".)

Keep *Hot Policy Pages* Here

Hot Policy Pages are important updates to this Member Handbook and are one way Basic Health provides you with official notice of program changes; you will receive them periodically, usually with your monthly billing statement. Keep these updates, along with this *Member Handbook* and other information you receive from Basic Health handy, so that you have the information you need to make the most of your Basic Health coverage.

For information on providers available to you and approval of specific services, call your health plan.

Washington State Health Care Authority
Basic Health
PO Box 42683
Olympia, WA 98504-2683

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Actuarial Report
Basic Health Program's Benefit Design
Department of Social and Health Services
Medical Assistance Administration
State of Washington

Milliman USA, Inc. (Milliman) has been commissioned by the State of Washington Department of Social and Health Services Medical Assistance Administration (MAA) to prepare an actuarial report with respect to the actuarial value of coverage of the benchmark plan selected by MAA and the actuarial value of coverage offered under the proposed Benefit Package for parents of Medicaid Children. This benefit package is equivalent to the Basic Health (BH) Program administered by the Health Care Authority. The purpose of the actuarial memorandum is to demonstrate consistency with the requirements set forth in Title XXI of the Social Security Act. Specifically, this report has been prepared to illustrate that the proposed coverage has aggregate actuarial value equivalent to or better than the value of the benchmark package. This memorandum may not be appropriate for other purposes.

I. BENCHMARK BENEFIT PACKAGE

The benchmark benefit package selected by MAA for determination of actuarial equivalency is the Uniform Medical Plan (UMP). The UMP is a health benefits coverage plan that is administered by the state's Health Care Authority and generally available to state employees in the State of Washington. The UMP is a PPO plan. We assumed 90% in-network participation. A summary of the benefits provided under the UMP plan is provided in Appendix A.

II. BASIC HEALTH PROGRAM

MAA has chosen the Basic Health (BH) Program to provide health benefit coverage to parents of Medicaid eligible children. A summary of the BH's benefit design is provided in Appendix B.

III. DETERMINATION OF ACTUARIAL VALUES

A. METHOD

Actuarial cost models were developed for the benchmark benefit package and the proposed benefit package. These cost models provide the net projected per member per month cost of benefits. The models were developed using the *Milliman Health Cost Guidelines*™ (HCGs) as the standard utilization basis for the calculation of actuarial equivalency. The HCGs are an internal Milliman resource developed through research that provide standardized utilization rates and adjustment factors to reflect geographic area, demographics, and covered services. As required, the cost models were developed without taking into account any differences in coverage based on

the method of delivery or means of cost control or utilization used. The assumptions used in the actuarial analysis of the benchmark plan are the same as those used in the analysis of the proposed plan. The assumptions have been used consistently throughout the actuarial analysis.

B. ASSUMPTIONS

Utilization Factors

Utilization factors in the actuarial cost models were developed using the HCGs with adjustments to reflect the benefit plan design, age and gender demographics, and geographic region. The HCGs starting utilization factors were adjusted to reflect the geographic region of the State of Washington. The geographic region adjustment was required since the starting factors are nationwide average values.

Price Factors

The price factors were developed based on average commercial reimbursement, discounted by 50% to approximate Medicaid reimbursement rates. Prescription drugs were discounted by a lesser amount to reflect typical marketplace savings. This basis was chosen as the standardized set of pricing assumptions.

Cost Sharing

Cost sharing amounts, including copays, coinsurance and deductibles, are used to reduce the price factors, where applicable.

Age/Gender Adjustments

The age and gender factors for both the benchmark plan and the proposed plan reflect the utilization of a standardized commercial population representative of the expected adult population to be covered under the proposed plan. Appendix C contains the distribution of adults assumed in the model. The population is derived from a typical commercial population of adults with dependent children contained in the Milliman HCGs.

Actuarial Cost Models

Appendix D contains the actuarial cost models for the benchmark benefit package and the proposed benefit package. The actuarial cost models provide the projected annual utilization rates per thousand, average charge, values of copays and coinsurance, and net claim cost by service category. The net claim costs are based on a July 1, 2001 claim date.

IV. ACTUARIAL EQUIVALENCY

The cost models shown in Appendix D illustrate the net claim cost per member per month for the benchmark benefit plan and the proposed plan. As shown in Table 1, the actuarial value of the proposed plan is roughly equivalent to (slightly greater than) the benchmark plan.

Table 1

STATE OF WASHINGTON
MEDICAL ASSISTANCE ADMINISTRATION
Summary of Aggregate Actuarial Value
Per Member Per Month Value (PMPM)

Plan	PMPM Value
UMP – Benchmark Plan	$96.20
BH – Proposed Plan	$96.46

V. CERTIFICATION

I, Timothy S. Barclay, am an Actuary with the firm of Milliman USA, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. The report has been prepared in accordance with the principles and standards of the Actuarial Standards Board of the American Academy of Actuaries. I was retained by the State of Washington Department of Social and Health Services Medical Assistant Administration to render an opinion on the actuarial value of coverage of the benchmark benefit package and the proposed benefit package. I meet the qualification standards set forth in Title XXI for rendering such an opinion.

In my opinion, the benchmark equivalent coverage proposed by the State of Washington in the form of BH meets the following requirements:

1. The coverage includes benefits for items and services within each of the categories of basic services described in Section 2103(c)(1) of the Social Security Act.

2. The coverage has an aggregate actuarial value that is at least actuarially equivalent to the State employee benefit plan, UMP.

3. With respect to each of the categories of additional services described in Section 2103(c)(2) of the Social Security Act for which coverage is provided by the proposed plan, the coverage has an actuarial value that is equal to at least 75% of the actuarial value of the coverage of that category of services in the State employee benefit plan, UMP.

4. The analysis was prepared using generally accepted actuarial principles and methodologies.

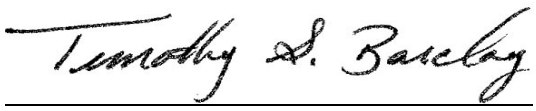
5. The analysis used a standardized set of utilization and price factors.

6. The analysis used a standardized population that is representative of the expected adult population to be covered under the proposal.

7. The analysis used the same principles and factors in comparing the value of different coverage.

8. The analysis was performed without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.

9. The analysis took into account the ability of the State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the proposed plan that results from the limitations on cost sharing under such coverage.



October 31, 2001
Date

Timothy S. Barclay, FSA, MAAA
Consulting Actuary
Milliman USA, Inc.
1301 Fifth Avenue, Suite 3800
Seattle, WA 98101-2605
(206) 504-5603

Appendix A
Uniform Medical Plan
Schedule of In-Network and Out-of-Network Benefits

Annual medical/surgical deductible: $200/person, $600/family for preferred, non-preferred, and out-of-area providers.

Annual prescription drug deductible: $100/person, $300/family for participating, nonparticipating, and out-of-area pharmacies. This is a combined retail and home delivery (mail-order) deductible and is separate from the annual medical/surgical deductible.

Annual medical/surgical out-of-pocket limit: $1,125/person, $2,250/family for preferred and out-of-area providers.

Lifetime maximum: The total amount the UMP will pay for any enrollee is $1,000,000.

Chemical dependency limit: $10,680 per 24 months for Inpatient and Outpatient.

Mental health limit: 10 Inpatient day max/year; 20-outpatient visit max/year.

Therapy limit: 60-days inpatient; 60 treatments outpatient.

Out-of-area benefit: 80%.

Benefits	In-Network Benefit	Out-of-Network Benefit
Inpatient Hospital Services	100% after $200 copay/day; $600 max copay/year	60%
Outpatient Hospital & Ambulatory Services	90%	60%
Ambulance	80%	80%
Physician Services & Supplies (including limited alternative care providers)	90%	60%
Preventive Care, Well-Baby Care, & Family Planning	100%	60%
Emergency Room	90% after $75 copay	80% after $75 copay
Home Health Care	90%	60%
Prescription Drug • Retail: 80% Generic / 70% Single-Source Brand / 50% Multi-Source Brand. Maximum coinsurance of $75/prescription. • Home delivery (mail order): Copays are $5 Generic / $30 Single-Source Brand / $40 Multi-Source Brand.		

Appendix B
Basic Health Program's
Schedule of Benefits

Annual deductible/coinsurance: None

Out-of-network / out-of-area benefit: None, except for emergency care.

Chemical dependency limit: Coverage limited to $5,000 every 24 months with a $10,000 lifetime maximum.

Mental health limit: Coverage limited to 10 Inpatient Days and 12 Outpatient Visits.

Benefits	Cost Sharing
Inpatient Hospital Services	$100 copay per admission; $500 maximum.
Outpatient Hospital & Ambulatory Services	$25 copay
Emergency Room	$50 copay
Ambulance	$50 copay
Physician Services & Supplies	$10 per office or home visit
Preventive Care, Well-Baby Care, & Family Planning	No copay
Maternity Care	No copay
Pharmacy	Tier 1: $1 Copay Tier 2: $5 copay Tier 3: 50%

Appendix C
Department of Social and Health Services
Medical Assistance Administration
State of Washington

Distribution of Parents of Medicaid Children

Age Bracket	Membership
Adult Male	
< 25	1.06%
25-29	3.60%
30-34	7.71%
35-39	10.18%
40-44	11.01%
45-49	8.82%
50-54	4.36%
55-59	1.39%
60-64	0.37%
65+	0.06%
Adult Female	
< 25	1.25%
25-29	3.98%
30-34	8.33%
35-39	10.93%
40-44	11.64%
45-49	9.08%
50-54	4.42%
55-59	1.39%
60-64	0.38%
65+	0.04%
Children	
0-1	0.00%
2-6	0.00%
7-18	0.00%
19-22	0.00%
Total	100.00%

Appendix D - 1
State of Washington Medical Assistance Administration - Actuarial Equivalency
Uniform Medical Plan (In-Network Benefits)
Estimated Medical Cost as of July 1, 2001

Benefit	Utilization Per 1,000	Allowed Average Charge	Per Member Per Month Claim Cost	Copay	Per Member Per Month Cost Sharing Value	Per Member Per Month Net Claim Cost
Hospital Inpatient						
Medical	85 Days	$1,075.39	$7.62	$201.64	$0.40	$7.22
Surgical	51 Days	1,787.15	7.66	201.64	0.20	7.46
Psychiatric	13 Days	426.38	0.45		0.00	0.45
Alcohol & Drug Abuse	12 Days	308.04	0.30	201.64	0.04	0.26
Maternity	40.5 Days	1,042.26	3.52	201.64	0.36	3.16
Skilled Nursing Care	8 Days	235.40	0.15	201.64	0.01	0.14
	209 Days		$19.70		$1.01	$18.69
Hospital Outpatient						
Emergency Room	113 Cases	$158.46	$1.50	$50.00	$0.47	$1.03
Surgery	103 Cases	682.63	5.85		0.00	5.85
Radiology	230 Cases	247.50	4.74		0.00	4.74
Laboratory	248 Cases	80.11	1.66		0.00	1.66
Pharmacy and Blood	269 Services	30.53	0.68		0.00	0.68
Cardiovascular	110 Services	54.39	0.50		0.00	0.50
PT/OT/ST	38 Services	40.52	0.13		0.00	0.13
Other	93 Services	97.23	0.75		0.00	0.75
Maternity Non-Delivery	11.3 Cases	326.95	0.31		0.00	0.31
			$16.12		$0.47	$15.65
Physician						
Inpatient Surgery	41 Proced.	$1,012.55	$3.44		$0.00	$3.44
Outpatient Surgery	484 Proced.	204.45	8.25		0.00	8.25
Anesthesia	85 Proced.	331.60	2.35		0.00	2.35
Inpatient Visits	144 Visits	53.59	0.64		0.00	0.64
Office/Home Visits	3,329 Visits	32.34	8.97		0.00	8.97
Urgent Care Visits	84 Visits	51.46	0.36		0.00	0.36
Consults	169 Consults	87.03	1.22		0.00	1.22
Emergency Room Visits	87 Visits	78.44	0.57		0.00	0.57
Immunizations & Injections	428 Proced.	29.45	1.05		0.00	1.05
Allergy Tests & Injections	1,078 Proced.	8.78	0.79		0.00	0.79
Physical Exams (Physician)	191 Exams	77.17	1.23		0.00	1.23
Vision, Hearing, Speech Exams	288 Exams	33.78	0.81		0.00	0.81
Physical Therapy	837 Services	16.47	1.15		0.00	1.15
Maternity Deliveries	21.4 Cases	1,149.43	2.05		0.00	2.05
Maternity Non-Deliveries	13.5 Cases	162.39	0.18		0.00	0.18
Radiology	1,258 Proced.	68.34	7.16		0.00	7.16
Laboratory	3,374 Proced.	18.95	5.33		0.00	5.33
Outpatient Psychiatric	518 Visits	53.39	2.30		0.00	2.30
Outpatient Alcohol & Drug Abuse	66 Visits	44.84	0.25		0.00	0.25
Chiropractor	1,367 Visits	21.15	2.41		0.00	2.41
Podiatrist	81 Visits	51.87	0.35		0.00	0.35
Misc. Medical	840 Proced.	36.56	2.56		0.00	2.56
			$53.42		$0.00	$53.42
Other						
Prescription Drugs	6,674 Scripts	$49.46	$27.51	$12.47	$6.93	$20.58
PDN/Home Health	39 Visits	133.17	0.43		0.00	0.43
Ambulance	24 Runs	154.48	0.31		0.00	0.31
DME/Prosthetics	115 Units	99.76	0.96		0.00	0.96
Glasses/Contacts	160 Services	129.16	1.72		0.00	1.72
Alternative Medicine	188 Visits	62.76	0.98		0.00	0.98
Smoking Cessation	30 Cases	250.00	0.63		0.00	0.63
			$32.54		$6.93	$25.61
Total Medical Cost			$121.78		$8.41	$113.37
Value of Deductible						(9.41)
Value of Coinsurance						(7.46)
Value of Out-of-Pocket Maximum						1.24
Total Medical Cost After Deductible and Coinsurance						$97.74

Appendix D - 2
State of Washington Medical Assistance Administration - Actuarial Equivalency
Uniform Medical Plan (Out-of-Network Benefits)
Estimated Medical Cost as of July 1, 2001

Benefit	Utilization Per 1,000	Allowed Average Charge	Per Member Per Month Claim Cost	Copay	Per Member Per Month Cost Sharing Value	Per Member Per Month Net Claim Cost
Hospital Inpatient						
Medical	85 Days	$1,075.39	$7.62		$0.00	$7.62
Surgical	51 Days	1,787.15	7.66		0.00	7.66
Psychiatric	13 Days	426.38	0.45		0.00	0.45
Alcohol & Drug Abuse	12 Days	308.04	0.30		0.00	0.30
Maternity	40.5 Days	1,042.26	3.52		0.00	3.52
Skilled Nursing Care	8 Days	235.40	0.15		0.00	0.15
	209 Days		$19.70		$0.00	$19.70
Hospital Outpatient						
Emergency Room	109 Cases	$158.46	$1.43	$50.00	$0.45	$0.98
Surgery	103 Cases	682.63	5.85		0.00	5.85
Radiology	230 Cases	247.50	4.74		0.00	4.74
Laboratory	248 Cases	80.11	1.66		0.00	1.66
Pharmacy and Blood	269 Services	30.53	0.68		0.00	0.68
Cardiovascular	110 Services	54.39	0.50		0.00	0.50
PT/OT/ST	38 Services	40.52	0.13		0.00	0.13
Other	93 Services	97.23	0.75		0.00	0.75
Maternity Non-Delivery	11.3 Cases	326.95	0.31		0.00	0.31
			$16.05		$0.45	$15.60
Physician						
Inpatient Surgery	41 Proced.	$1,012.55	$3.44		$0.00	$3.44
Outpatient Surgery	484 Proced.	204.45	8.25		0.00	8.25
Anesthesia	85 Proced.	331.60	2.35		0.00	2.35
Inpatient Visits	144 Visits	53.59	0.64		0.00	0.64
Office/Home Visits	3,070 Visits	32.34	8.27		0.00	8.27
Urgent Care Visits	76 Visits	51.46	0.32		0.00	0.32
Consults	164 Consults	87.03	1.19		0.00	1.19
Emergency Room Visits	83 Visits	78.44	0.55		0.00	0.55
Immunizations & Injections	404 Proced.	29.43	0.99		0.00	0.99
Allergy Tests & Injections	1,019 Proced.	8.78	0.75		0.00	0.75
Physical Exams (Physician)	173 Exams	77.17	1.11		0.00	1.11
Vision, Hearing, Speech Exams	265 Exams	33.76	0.74		0.00	0.74
Physical Therapy	772 Services	16.47	1.06		0.00	1.06
Maternity Deliveries	21.4 Cases	1,149.43	2.05		0.00	2.05
Maternity Non-Deliveries	13.5 Cases	162.39	0.18		0.00	0.18
Radiology	1,195 Proced.	68.19	6.79		0.00	6.79
Laboratory	3,181 Proced.	18.96	5.03		0.00	5.03
Outpatient Psychiatric	472 Visits	53.39	2.10		0.00	2.10
Outpatient Alcohol & Drug Abuse	61 Visits	44.84	0.23		0.00	0.23
Chiropractor	1,235 Visits	21.15	2.18		0.00	2.18
Podiatrist	73 Visits	51.87	0.31		0.00	0.31
Misc. Medical	792 Proced.	36.54	2.41		0.00	2.41
			$50.94		$0.00	$50.94
Other						
Prescription Drugs	6,434 Scripts	$49.47	$26.52	$12.47	$6.69	$19.83
PDN/Home Health	39 Visits	133.17	0.43		0.00	0.43
Ambulance	24 Runs	154.48	0.31		0.00	0.31
DME/Prosthetics	115 Units	99.76	0.96		0.00	0.96
Glasses/Contacts	160 Services	129.16	1.72		0.00	1.72
Alternative Medicine	188 Visits	62.76	0.98		0.00	0.98
Smoking Cessation	30 Cases	250.00	0.63		0.00	0.63
			$31.55		$6.69	$24.86
Total Medical Cost			$118.24		$7.14	$111.10
Value of Deductible						(8.63)
Value of Coinsurance						(35.87)
Value of Out-of-Pocket Maximum						15.71
Total Medical Cost After Deductible and Coinsurance						$82.31

Appendix D - 3
State of Washington Medical Assistance Administration - Actuarial Equivalency
Basic Health Plan with Cost Sharing
Estimated Medical Cost as of July 1, 2001

Benefit	Utilization Per 1,000	Allowed Average Charge	Per Member Per Month Claim Cost	Copay	Per Member Per Month Cost Sharing Value	Per Member Per Month Net Claim Cost
Hospital Inpatient						
Medical	85 Days	$1,075.39	$7.62	$100.00	$0.18	$7.44
Surgical	51 Days	1,787.15	7.66	100.00	0.10	7.56
Psychiatric	13 Days	426.38	0.45	100.00	0.02	0.43
Alcohol & Drug Abuse	11 Days	308.04	0.27	100.00	0.02	0.25
Maternity	40.5 Days	1,042.26	3.52			3.52
Skilled Nursing Care	8 Days	235.40	0.15			0.15
	208 Days		$19.67		$0.32	$19.35
Hospital Outpatient						
Emergency Room	117 Cases	$158.46	$1.55	$50.00	$0.49	$1.06
Surgery	103 Cases	682.63	5.85	25.00	0.21	5.64
Radiology	230 Cases	247.50	4.74			4.74
Laboratory	248 Cases	80.11	1.66			1.66
Pharmacy and Blood	269 Services	30.53	0.68			0.68
Cardiovascular	110 Services	54.39	0.50	25.00	0.11	0.39
Other	93 Services	97.23	0.75	25.00	0.10	0.65
Maternity Non-Delivery	11.3 Cases	326.95	0.31			0.31
			$16.04		$0.91	$15.13
Physician						
Inpatient Surgery	41 Proced.	$1,012.55	$3.44			$3.44
Outpatient Surgery	484 Proced.	204.45	8.25			8.25
Anesthesia	85 Proced.	331.60	2.35			2.35
Inpatient Visits	141 Visits	53.59	0.63			0.63
Office/Home Visits	3,127 Visits	32.34	8.43	10.00	2.61	5.82
Urgent Care Visits	81 Visits	51.46	0.35	10.00	0.07	0.28
Consults	166 Consults	87.03	1.20			1.20
Emergency Room Visits	90 Visits	78.44	0.59			0.59
Immunizations & Injections	415 Proced.	29.30	1.01			1.01
Allergy Tests & Injections	1,028 Proced.	8.78	0.75			0.75
Physical Exams (Physician)	210 Exams	77.17	1.35			1.35
Vision, Hearing, Speech Exams	42 Exams	25.02	0.09	10.00	0.03	0.06
Maternity Deliveries	21.4 Cases	1,149.43	2.05			2.05
Maternity Non-Deliveries	13.5 Cases	162.39	0.18			0.18
Radiology	1,206 Proced.	68.22	6.85			6.85
Laboratory	3,258 Proced.	18.94	5.14			5.14
Outpatient Psychiatric	397 Visits	53.39	1.77	10.00	0.33	1.44
Outpatient Alcohol & Drug Abuse	40 Visits	44.84	0.15	10.00	0.03	0.12
Misc. Medical	800 Proced.	36.55	2.44			2.44
			$47.02		$3.07	$43.95
Other						
Prescription Drugs	6,968 Scripts	$55.78	$32.39	$26.01	$15.10	$17.29
PDN/Home Health	39 Visits	133.17	0.43			0.43
Ambulance	24 Runs	154.48	0.31	50.00	0.10	0.21
DME/Prosthetics	5 Units	244.64	0.10			0.10
			$33.23		$15.20	$18.03
Total Medical Cost			$115.96		$19.50	$96.46

DRAFT

ATTACHMENT D
Feasibility Study For Employer-Sponsored Insurance

Washington State has been a national leader in providing health care to its low-income populations. This leadership includes efforts to partner with employers to provide health care coverage for employees. Partnering with employers has proceeded in a variety of ways. These approaches include the Medicaid Health Insurance Premium Program, the Evergreen Health Insurance Program, the Basic Health program, the Washington State Health Insurance Pool, and community access initiatives. Despite these efforts, however, partnering with employers to provide health care coverage has not yielded a high rate of success.

DSHS proposes as part of the MSRW demonstration project to conduct a feasibility study for employer-sponsored insurance (ESI) that would 1) explore Washington's ESI experience to date, 2) identify viable options for an ESI pilot, and 3) determine the feasibility of implementing an effective ESI program. The following comments add perspective to the state's current ESI efforts.

HISTORICAL CONTEXT

1. MEDICAID HEALTH INSURANCE PREMIUM PROGRAM

In January 2002, nearly 80,000 of the state's Medicaid population had been identified as having third party coverage. During the same period, the Medical Assistance Administration (MAA) purchased premiums for about 3,000 clients, of which nearly 80 percent were Medicare clients.

As permitted under the Omnibus Budget Reconciliation Act of 1990, the state purchases premiums for Medicaid clients when it is determined that the cost of the subsidy is no more than what it otherwise would have cost Medicaid. Four types of insurance policies are considered for premium assistance.

A. Individual Policies: Some Medicaid clients have purchased individual health insurance policies directly through an insurance company. If cost-effective, and once the client becomes Medicaid eligible, MAA will pay the premium by sending payment directly to the insurance company on a monthly, bimonthly, or quarterly basis.

B. COBRA Policies: The 1986 Consolidated Omnibus Budget Reconciliation Act (COBRA) allows certain workers who lose their health benefits to continue their group coverage. Again, if cost-effective and once the client becomes Medicaid eligible, MAA will pay the premium, in accordance with federal law, but usually directly to the COBRA administrator on a monthly basis.

C. Employer-sponsored Plans: Some Medicaid clients are currently covered by an employer-sponsored health plan. Each month, premiums are deducted from employees' paychecks for their and their dependents' health coverage. Premium costs for the employees can range from nothing to the full cost of the premiums. When determined to be cost-effective, MAA will usually reimburse the client for the cost of the premium. MAA will request a copy of the paycheck for verification before reimbursement is issued.

D. Medicare Supplement: Clients that are eligible for both Medicare and Medicaid may have a Medicare supplement policy. When cost-effective, MAA will purchase the premiums by sending payments directly to the insurance company.

MAA has aggressively pursued strategies to identify Medicaid clients who may have available employer-sponsored or other insurance. Some of these strategies include:

- Notification by DSHS Community Services Offices at the time of application for Medicaid;
- Notification by Medicaid providers;
- Notification by DSHS support enforcement staff who make certain absent parents are comporting with requirements to maintain health care for dependents;
- Notification by clients who fill out an MAA Health Insurance Questionnaire; and,
- A quarterly data match with the Employment Security Department for eligibles who have reported income within the last four quarters.

In the first 11 months of SFY 2002, these strategies have augmented cost avoidance and recovery efforts totaling over $104 million.

2. THE EVERGREEN HEALTH INSURANCE PROGRAM

In 1989, the Washington State Legislature directed DSHS through RCW 74.09.757 to initiate a premium assistance program for persons with HIV/AIDS, called the Evergreen Health Insurance Program (EHIP). Under EHIP, purchasing the premium is cost-effective for the state because it helps persons retain employment and health insurance and avoids their having to obtain Medicaid coverage.

To be eligible, a person must be diagnosed with HIV/AIDS, earn less than 370 percent of the federal poverty level, have total personal assets of less than $15,000, be a resident of Washington, and not be otherwise eligible for Medicaid or any other Medical Assistance program. (The financial eligibility criteria are currently under review to address savings requirements directed in the supplemental budget.)

Currently, the state contracts with the Seattle-based Lifelong AIDS Alliance to administer the program for some 730 enrolled persons.

3. THE BASIC HEALTH PROGRAM

In 1987, the Health Care Access Act established the Washington Basic Health Plan. The plan was created as a pilot project to provide access to health insurance for low-income Washington residents through a state-sponsored introduction to health care and health insurance. The plan also was to partner with the private sector using a market-based approach.

Revised under state law by the Health Services Act of 1993, the Basic Health program was made a permanent statewide program administered by the Health Care Authority. It was further directed to administer an employer group program that allowed employers to pay their employees' Basic Health premiums.

To be eligible for group enrollment, an employer must be licensed to do business in Washington, have employees in addition to the business owner, not offer other health insurance to the same classification of employees, and enroll at least 75 percent of their eligible employees within a classification of employees (not counting those who waive coverage.) Also, employees must meet all Basic Health eligibility requirements such as: be a Washington resident; not be eligible for Medicare; and not be institutionalized at the time of enrollment.

The program requires a minimum employer fee and participation of at least 75 percent of employees within a classification of employee. To simplify the process and make it easier for employers to estimate their costs, a flat fee was established that is based upon the average employee contribution.

The employer is billed a total premium amount for all members enrolled through the group, and may collect a portion of the premium from each employee. Employers also are required to pay a minimum fee of $25 per part-time employee and $45 per full-time employee. For reduced-premium members, $10 of that fee is required to reduce the amount the employee would pay if enrolled as an individual, and the remainder is used to offset the cost to the state. For full-premium members, the entire employer fee is used to offset the cost to the employee; there is no state-paid portion of their premium.

The program experienced rapid growth in earlier years, 588 in June 1997 to 5,076 in April 1998, but has steadily declined since then, in part because full-premium coverage is no longer available in most counties. In May 2002, 781 members were enrolled.

4. WASHINGTON STATE HEALTH INSURANCE POOL

The Washington State Health Insurance Pool (WSHIP) was created in 1987 to provide fee-for-service health insurance at 150 percent of average rates to individuals who had been denied "substantially equivalent" coverage by an insurer, usually because of costly medical conditions. Subsequently a managed care product was added to WSHIP plans at 125 percent of average rate.

As part of a 1993 major health reform measure, insurers were required to "guarantee the issuance" of coverage to anyone who applied. As the result of these changes, WSHIP was no longer in great need because no one could be ***denied*** coverage in the private market. However, as individual plans dwindled in the late 1990's, the Legislature, in an effort to placate insurers and, hopefully, increase the availability of private coverage in the state, repealed the "guarantee issue" provision. Thus, WSHIP became once again a source of coverage for high cost enrollees.

Under the 2000 law, health-insurance applicants in the individual market are required to undergo a "health screen." The screen is a questionnaire designed (based on medical history) to identify the 8 percent most costly potential enrollees for individual health insurance. If an applicant is identified as too costly for normal individual coverage, an insurer could reject him or her. However, the rejected applicant is then permitted to buy coverage in the WSHIP, which is comprehensive coverage but at higher rates. In addition to the screening provisions, the new law lengthened the preexisting condition limitation period from three to nine months to prevent, what insurers call, enrollee "gaming" of the system. These provisions apply only to individual (not group) coverage. Also, persons coming off of COBRA coverage can not be screened out. With the passage of this 2000 statute, access to WSHIP coverage became Washington State's method of complying with the HIPAA portability requirements.

5. COMMUNITIES IN CHARGE

Local communities in Washington State have a long history of proactive involvement in shaping their health systems and addressing specific issues such as access to health services. Over the past four decades, organizing efforts and leadership in numerous communities have helped to create federally funded community and migrant health centers and locally financed public hospital districts, both of which are critical to assuring access to health services throughout the state. From the early 1970s through the mid-1980s, regional comprehensive health planning agencies and, later, the state's four federally funded health systems agencies were actively convening community forums for local health system development. Other important local efforts have focused on recruiting and retaining health professionals, creating community care networks (often involving local business and political leaders), and strengthening public health and health promotion efforts.

The reoccurrence of rising costs, eroding access, disruptions in health insurance markets, and financial instability among health care providers has once again spurred communities to consider

creative initiatives. To support these local efforts, three funding sources have emerged: the Robert Wood Johnson Foundation's **Communities in Charge** (CIC) grants, the federal Health Resources and Services Administration's (HRSA) **Community Access Program** (CAP) grants; and the Washington Health Foundation's (WHF) **Rural Health Viability Grant Program**. These sources currently fund five major community access projects :

(1) **Community Choice**--Wenatchee [CAP],
(2) **Inland Northwest In Charge Initiative**—Spokane area [CAP & CIC],
(3) **Kids Get Care--**Seattle/King County [CAP],
(4) **Rural Health Reform Workgroup**--Jefferson County [WHF], and
(5) **100% Access Project**--five western counties [CAP & WHF].
(See descriptive chart below)

These projects have formed the ***Communities That Won't Wait Caucus (CTWWC),*** which meets periodically for information sharing and mutual problem solving. The Caucus is strongly supported by the state's various health agencies offering consultation and other forms of technical assistance.

Also, Washington State's HRSA-funded State Planning Grant on Access to Health Insurance has been evaluating these programs and has identified a number of state actions that could strengthen state-community collaborations, facilitate partnerships to improve access, and support local initiatives, such as:

- Create a "Community Access Ombudsman Office" that could act as a single point of contact for communities, promote state-community partnerships, or advocate for the interests of community access initiatives regarding funding opportunities and with state agencies.

- Develop community access partnerships that involve: information sharing to promote timely enrollment to needed services; care management pilot projects; collaboration among agency medical directors and local providers on utilization issues, network adequacy, and HIPAA implementation; and use of retired dentists to serve low-income people.

- Investigate alternative contracting models for Medicaid and Basic Health services, including decentralized models developed with selected community access initiatives.

- Develop a single focus for communities and providers for state health policy development.

- Promote administrative simplicity by investigating: the use of "smart card" technology; and establishing a single point of entry or unified application for Healthy Options and Basic Health.

MAJOR COMMUNITY ACCESS PROJECTS

Title & *Lead Agency*	Target Groups	Project Goals	Funding
Community Choice HealthCare Network ***Community Choice, Wenatchee***	Residents of Chelan, Douglas, and Okanogan counties.	Develop strategies to support providers and community members to facilitate enrollment in existing public programs and target resources to needs; expand insurance coverage; and improve clinical and patient information systems.	CAP
Inland Northwest in Charge Initiative ***Health Improvement Partnership, Spokane***	Uninsured residents of eleven counties in Eastern Washington.	Develop strategies to facilitate enrollment in existing programs and use existing funds more efficiently; expand access to existing resources; develop effective care management systems; and improve patient referral and information systems.	CAP & CIC
Kids Get Care ***King County Health Action Plan, Public Health, Seattle & King County***	Children aged 0-5 in three communities of King County with a high concentration of uninsured children.	Improve early screening for physical, oral, and developmental health status; link children to health care homes through local providers and community organizations; assure children receive basic health care services regardless of insurance status; and improve children's health status.	CAP
Rural Health Reform Workgroup ***Jefferson County Public Hospital Dist. #2 / Jefferson County Board of Health***	Residents of Eastern Jefferson County	Develop an effective community decision-making process; increase access for all area residents; and develop a sustainable system of health service providers.	WHF
100% Access Project ***CHOICE Regional Health Network, Olympia***	93,000 residents <250% FPL in Grays Harbor, Lewis, Mason, Pacific, and Thurston counties.	Develop coordinated access to uniform set of services; ensure adequate funding; and sustain provider networks.	CAP & WHF

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EMPLOYER-SPONSORED INSURANCE FEASIBLITY STUDY

In evaluating the feasibility of implementing ESI in Washington State, DSHS will partner with staff from the Washington State Planning Grant on Access to Health Insurance, contingent on their receiving grant funding. Under this state coverage initiative, the department will initiate a study by January 2003, and will complete the study by March 2004. The study will evaluate costs and benefits of helping families with income up to 200 percent of the federal poverty level purchase employer-sponsored insurance coverage. Part of the study will be a close examination of the state's past efforts to partner with private entities in providing access to health care through employer-sponsored insurance and premium assistance programs. After completion of the study, DSHS will report to CMS on viable options and the feasibility of implementing such a program in Washington State.

To help focus public programs and employer-sponsored insurance partnership efforts, creation of an Advisory Committee would be considered to serve as the overarching policy committee with wide representation from key stakeholders, business, communities, legislators, and public programs. Moreover, the Advisory Committee could provide oversight to the ESI feasibility study. We propose that the study would concentrate its research efforts in six areas: 1) Funding streams; 2) Subsidies; 3) Benefit design; 4) Target populations; 5) Substitution; and, 6) Legislative action. Potential areas of study include:

A. Funding Streams

- How would an ESI pilot project be funded?
- Would Medicaid funds be used?
- Would SCHIP funds be used?
- How would public/private administration interfaces be defined?
- Would employers be willing to adjust payroll deductions?

B. Subsidies

- Would premium subsidies be provided for low-income employees (those under 200 percent of the FPL)?
- Would subsidies be provided for employers who want to offer health care for their employees?
- What would be the minimum amount an employer would be required to contribute?
- Would employees be required to contribute toward the cost of their health care?
- Would contribution be determined using a sliding scale model, with those at the higher income threshold contributing more toward the cost of their care?
- Would employers be willing to adjust payroll deductions?
- Would employer subsidy be a fixed amount?

C. Benefit Design

- What would the benefit design look like, whether under Medicaid or SCHIP funding?
- What level of benefits would be affordable for employees, employers, and the state while still offering a comprehensive package?

D. Target Populations

- What populations would be eligible for enrollment?
- Would eligibility be offered to both full-time and part-time employees?
- What enrollment guidelines would be adopted?

E. Substitution

- What strategies could be employed to prevent substitution?
- Would employer-based subsidies be limited to employers with 50 or less employees?
- Would employees be required to be uninsured for a given time period before they can be eligible

F. Legislative Action

- What legislative action is needed to implement an ESI pilot project?

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ATTACHMENT E
Cost Sharing

Washington State's MSRW demonstration project will impose both copayment and premium requirements. The adoption of targeted copayments is to encourage appropriate use of medical services, while the adoption of premiums is to invest clients in their health care coverage by contributing towards the cost of their medical coverage.

In accordance with federal trust responsibility to provide health care, neither copayments nor premiums will be imposed on Medicaid or SCHIP clients who are American Indians or Alaska Natives (AI/AN).

1. Copayments.

Copayments will be used to encourage and direct appropriate use of medical services. Copayments will not be used as a mechanism for having clients share in the cost of their medical coverage. Premiums will be used to achieve that objective. Copayments will be required for all Medicaid and SCHIP clients (except AI/AN), both mandatory and optional eligibility groups.

A. Brand-Name Drug Copayment.

A $5.00 copayment will be applied selectively to brand-name drugs that have generic equivalents or to nonpreferred drugs in a therapeutic class with a preferred drug.[1] Washington will be able to selectively impose the copayment on brand-name or nonpreferred drugs as prices, utilization and introduction of new drugs or therapeutic classes evolve.

Copayment will be waived if the drug is deemed medically necessary by the client's prescriber. Within the scope of their practice, pharmacists will be able to substitute a less costly generic drug or preferred drug in the therapeutic class if the client does not pay the copayment.[2] However, pharmacists will not be able to deny prescriptions if the client is unable to pay the copayment.

[1] Twenty-eight (65 percent) of 43 states surveyed in the Kaiser Commission study on prescription drugs, reported using prescription drug copayments in 2001. Seventeen (61 percent) of the 28 states had a single rate copayment; 6 (21 percent) states used a sliding-scale copayment based on the price of the drug; and 5 (18 percent) states employed different copayment rates for brand-name and generic drugs. Source: Kaiser Commission on Medicaid and the Uninsured, Policy Brief, "Medicaid: Purchasing Prescription Drugs", (January 2002).

[2] Washington State pharmacists' scope of practice is set forth in Chapter 69.41 RCW and Chapter 246.899 WAC.

B. Hospital Emergency Room Copayment.

A $10.00 copayment will be imposed for the nonemergent use of hospital emergency rooms.[3] Hospitals will be allowed to require that clients arrange for appointments with their primary care providers or clinics for nonemergent care.

Washington's Medicaid managed care (Healthy Options) program requires its contracting health plans to have a 24-hour, 7-day per week telephone access to a licensed health care professional for advice concerning emergent, urgent or routine medical conditions, and authorization of emergency and out-of-area urgent care. As part of its recently implemented disease management project, nurse consulting services will be made available to 150,000 aged and disabled persons. DSHS would also contract for 24-hour, 7-day week nurse consulting services for all other Medicaid clients as part of the MSRW demonstration.

Under the demonstration, hospitals will be allowed to require that a client contact the Medicaid consulting nurse by telephone to discuss whether the client has an emergent medical condition that requires emergency treatment in the hospital emergency room.

2. Premiums.

Washington's existing Medicaid and SCHIP programs have premium requirements for:

(a) Categorically Needy (CN) Transitional Medical Assistance (TMA) for families during the second 6-months of their coverage, as permitted under Section 1925(b)(5) of the Social Security Act. The monthly premium amount is 3 percent of a family's gross income minus childcare. The premium is applied to those families with incomes above 100 percent of the Federal Poverty Level (FPL).

(b) CN Healthcare for Workers with Disabilities (HWD) program. As specified in the biennial operating budget, the premium amount is: 50 percent of unearned income above the MNIL, plus 5 percent of total unearned income, plus 2.5 percent of earned income after subtracting SSI earned income related deductions.

(c) SCHIP program, which has a $10.00 per month per child premium and a family maximum of $30.00 per month

Under Washington's MSRW demonstration, monthly premiums will be adopted for coverage of clients (except AI/AN) who are eligible for certain Medicaid CN Optional and Medically Needy

[3] Washington's Medicaid program has implemented a $3.00 copayment for visits to emergency rooms when a client is not found to have an emergency medical condition. The copayment is imposed on those eligibility groups permitted under Section 1916 of the Social Security Act.

(MN) eligibility groups, and who reside in households with gross income above 100 percent of FPL.

As with SCHIP and Basic Health, sponsors may pay premiums on behalf of clients. Sponsorship would include employers, providers and nonproviders.

The additional eligibility groups subject to premium requirements are:

(a) CN optional children - infants up to age one in households with incomes between 185 percent and 200 percent of the federal poverty level (FPL); children age one through five in households with incomes between 133 percent and 200 percent of FPL; and children age six through 18 in households with incomes between 100 percent and 200 percent of FPL;

(b) MN elderly persons who are age 65 and older and who meet the state's Medically Needy Income Limits (MNIL) through medical spenddown;

(c) MN blind and disabled persons who meet federal blind and disability standards and who meet the state's MNIL through medical spenddown; and,

(d) MN pregnant women and children who meet the state's MNIL through medical spenddown.

Washington's Medicaid and SCHIP monthly premium per person will be:

INCOME BAND	FPL MINIMUM	FPL MAXIMUM	MONTHLY PREMIUM	MAXIMUM PER FAMILY
A	100%	150%	$10.00	$30.00
B	151%	200%	$15.00	$45.00
C	+200%		$20.00	$60.00

There will be a maximum premium amount per month, based on a three-person household. The individual premium amounts are based on 1 percent of the income in that income band, averaged across one, two and three person households with one and two adults. Using this premium structure, the family maximum premium amount does not exceed 2 percent of a household's gross income. Under the demonstration, Washington will be able to adjust the premium amounts on an annual basis in accordance with the annual increase in FPL without a formal amendment of the approved demonstration.

Medical coverage will be terminated if the premiums are more than three months in arrears. If persons are terminated from coverage for nonpayment, they will be required to wait three months until they can re-enroll in the program. They also will be required to pay the full amount of their delinquent payment and will not be eligible for retroactive Medicaid eligibility.

Washington's MSRW demonstration requests waiving provisions of sections 1902(e)(1)(B), 1925(a)(4) and 1925(b)(5) to allow Washington to impose premiums at the start of TMA coverage and to adopt the same premium policies for its TMA program. The state will amend its SCHIP State Plan so that SCHIP clients have the same premium requirements. The state also will adopt the same grace period and delinquency policies for its HWD program's premium requirements.

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ATTACHMENT F
Measuring Progress

1. Insurance Coverage - The Washington State Population Survey (WSPS) methods

The WSPS was designed expressly to support analyses of health coverage and other issues of importance to the state. It is an on-going survey conducted by the Office of Financial Management (the state's budget and planning office) on a two-year interval (1998, 2000, and 2002). Data used herein are from a telephone survey in 2000 of 6,726 Washington households of the state's noninstitutionalized civilian population. Racial minority groups were over-sampled by design.

2.a. State Coverage Goals

The goal of Washington State's MSRW demonstration project is to sustain the state's current Medicaid coverage commitments and expand Basic Health (BH) program enrollment by 20,000 adults.

Washington has been a national leader in providing health coverage to children, elderly and disabled and working low-income residents through its Medicaid, SCHIP and BHP programs. Washington was one of four states covering children at or above 200 percent of poverty prior to enactment of SCHIP. The state's SCHIP program provides coverage to children in families up to 250 percent of poverty. Washington has an extensive home and community-based waiver program that provides medical and long-term care for some 33,000 persons. It is one of only 23 states that offers short-term Medically Needy (MN) coverage to elderly and disabled persons who do not qualify for Categorical Needy (CN) coverage due to excess income. And, the state now offers coverage to the working disabled through the Healthcare for Workers with Disabilities program and coverage to low-income women with breast and cervical cancer.

In addition, Washington has been providing health coverage to adults that do not qualify for Medicaid through its state-financed Basic Health (BH) program. The program this program was implemented in 1989. Today, BH is covering some 120,000 persons with incomes up to 200 percent of poverty.

Currently, Washington's Medicaid and SCHIP programs are providing health coverage to 535,000 children – one-third of all children in the state. In total, the Medicaid program is covering some 830,000 persons (excluding family planning). This is nearly 14 percent of all persons in the state. This coverage has helped reduce children's uninsured rates from 7.8 percent in 1998 to 7.2 percent in 2000, and the state's overall uninsured rate from 9.5 percent to 8.4 percent.[1]

[1] Source: Washington State Population Surveys (WSPS) for 1998 and 2000.

During the next three years (SFY 2003-05), Washington's Medicaid program's enrollment is projected to increase 4 percent per year. By June 2005, the program is forecasted to cover some 930,000 persons, and its SCHIP will cover 12,000 children above 200 percent of poverty. At that point, Washington's Medicaid and SCHIP program will be covering some 618,000 children – 38 percent of all children in the state.

In addition to helping sustain this anticipated growth in coverage, the MSRW demonstration project will provide funding to cover some 20,000 parents of Medicaid and BH children and childless adults through expansion in the BH program.

2.b. State Progress Reports

Tracking of the uninsured rate: Washington will track its uninsured rate, trends, and sources of coverage through the Washington State Population Survey. To complement this report and to the extent that funds are available, additional data may be collected through special research grant projects that focus on the uninsured, e.g., Washington's current HRSA grant on increasing health insurance coverage.

Evaluation*:* Washington will evaluate the impact of a premium requirement and enrollment freeze (if implemented) upon clients.

Premium Requirement: Enrollment will be monitored upon implementation. If disenrollment is significant, former clients will be surveyed to identify:

1. Causes of disenrollment,
2. Demographic and geographic profiles,
3. Economic status,
4. Health status and risk profiles, and
5. Anticipated source of health care while disenrolled.

Enrollment Freeze: If implemented, persons on the waiting list will be surveyed to identify:

1. Demographic and geographic profiles,
2. Health status and risk profiles, and
3. Anticipated source of health care while on the waiting list.

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ATTACHMENT G
Budget Worksheets

PENDING

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ATTACHMENT H
Additional Waivers

Washington State requests waivers of the following additional sections highlighted in bold to implement the MSRW demonstration project as described in this application. Washington State requests that CMS also grant any other waivers deemed necessary to implement the demonstration. Notwithstanding the waivers requested in Section VII and below, Washington State further requests that current Medicaid program and demonstration waivers granted to DSHS remain in effect and separate from this demonstration application, unless otherwise incorporated by specific reference in negotiated Special Terms and Conditions.

Cost-Sharing

Sections 1902(a)(14) and 1916 provide that no enrollment fees, premiums, or similar charges, and deductions, cost-sharing, or similar charges, may be imposed except as provided in these sections. Waiving these sections under the demonstration would allow reasonable copayments to be imposed on all mandatory and optional eligibility groups for brand-name drugs with generic or therapeutic equivalents and on nonemergent services provided in hospital emergency rooms. Both types of copayments would be subject to certain exceptions as described in Attachment E, with the underlying intent being to encourage and direct appropriate use of medical services.

The demonstration would also allow reasonable premiums to be imposed for medical coverage on certain optional Medicaid clients with income above 100 percent of poverty as described in Attachment E. Waiving the provisions of **sections 1902(e)(1)(B), 1925(a)(4), and 1925(b)(5)** would allow premiums during the initial six-month extension for transitional medical assistance (TMA) and eliminate the 3 percent limitation for TMA premiums, thereby allowing the same premium policy for TMA and other clients as described in Attachment E.

In accordance with federal trust responsibility to provide health care, neither copayments nor premiums would be imposed on Medicaid or SCHIP clients who are American Indians or Alaska Natives.

Enrollment Freeze

Section 1902(a)(34) requires a state to provide medical assistance retroactively for up to three months prior to the date that an application is made. Waiving this section under the demonstration for the purpose of an enrollment freeze as described in Attachment J would eliminate prior month(s) retroactive Medicaid eligibility and coverage for an optional group that is subject to a waiting list. When an enrollment freeze is removed, coverage for applicants would start the first of the month. For applicants who apply after enrollment limits are removed, their retroactive eligibility would be considered first looking back to the effective date of enrollment limits being removed, before considering regular retroactive eligibility under Medicaid. (The elimination of retroactive eligibility would also apply to optional clients terminated from

coverage due to nonpayment of premiums under the policy described in Attachment E.) A waiver of **section 1902(a)(8)** is also requested regarding furnishing assistance with reasonable promptness and a further waiver of **section 1902(a)(10)** is requested to the extent that its provisions may impair the ability to impose an enrollment freeze.

Sections 1902(a)(10) and (17) contain provisions regarding income and resource requirements for determining eligibility for medical assistance. If enrollment is frozen for the Medically Needy (MN) program while continuing to provide Categorically Needy (CN) optional coverage under a special income level, Miller Trust requirements would normally be allowed that permit income to be sheltered and may result in CN coverage. Also, clients' medical expenses incurred during an enrollment freeze would normally be used to meet financial participation and spenddown requirements for CN and MN programs. Waiving the appropriate Medicaid provisions in these sections under the demonstration to eliminate these financial eligibility issues would ensure achieving expected expenditure reductions associated with new clients and sustaining coverage for current clients. Furthermore, premiums imposed under the MSRW would not be allowed as an incurred medical expense for spenddown purposes.

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ATTACHMENT I
Public Process

The Department of Social and Health Services (DSHS) recognizes that the residents of Washington State have a legitimate interest in learning about the Medicaid and SCHIP Reform Waiver (MSRW) and have a legitimate interest in providing input through a public process. Toward that end, DSHS developed two goals for its public process: first, to make available information for all interested in learning about the MSRW; and, second, to afford all interested parties an opportunity to provide input prior to its submission.

STRATEGIES

DSHS devoted two months time and employed several strategies to accomplish its public process goals. First, DSHS provided a news release in the last week of April, announcing its intention to submit an amended MSRW. Second, over 1,500 notices were mailed inviting stakeholders to town hall meetings held in ten locations throughout the state. Third, DSHS presented information about the MSRW and elicited feedback at these meetings and utilized a feedback form that encouraged stakeholders to provide their input. Fourth, DSHS provided information on its MSRW Web site. Furthermore, DSHS held a Government-to-Government consultation with the 29 federally-recognized tribes in the state of Washington.

Additionally, DSHS staff from the Medical Assistance Administration (MAA) met with members of the Title XIX Advisory Committee, as well as representatives of its Healthy Options managed health care plan contractors, to share information about the MSRW and to provide an opportunity for feedback.

NEWS RELEASE

On May 14, 2002, DSHS made available to all local written media a news release that declared its intent to submit an amended MSRW to CMS. The news release was carried in papers of general circulation. It also provided a means by which interested parties could learn more about these activities and provide feedback, including the address of the MSRW Web site, and telephone numbers of MAA staff working on the project.

NOTICES

To increase public awareness about the MSRW, DSHS sent over 1,500 notices to stakeholders across the state. Stakeholders included clients, providers, and advocacy groups. The notice informed the public of DSHS' intent to submit an amended MSRW, how to find out more information about the MSRW, and announced the ten town hall meeting locations, dates, and times.

TEN TOWN HALL MEETINGS

Beginning on May 21, 2002, in the city of Spokane, DSHS held its first of ten town hall meetings. Each meeting was scheduled from 6:00 to 9:00 p.m. to provide a more convenient meeting time for local residents. The first of the three hours was used to provide a PowerPoint presentation that outlined the budget perspective and major elements of the proposed MSRW: co-payments, premiums, benefit design, an enrollment freeze, and SCHIP expansion. The remaining two hours were used to elicit comments, suggestions and questions from the audiences. The information obtained from each town hall meeting was documented by DSHS staff and subsequently posted for review on the MSRW Web site. Moreover, local newspapers reported on the town hall meetings in their communities. Follow-up articles appeared in the Tacoma News Tribune, the Longview Daily, the Seattle Post-Intelligencer, the Seattle Times, the Spokane Spokesman Review, the Olympian, the Tri-City Herald, the Yakima Herald-Republic, the Bellingham Herald, the Everett Herald, and the Port Angeles Daily.

The ten Town hall meeting dates and locations were: Spokane, May 21; Olympia, May 22; Tacoma, May 28; Bellingham, May 30; Port Angeles, June 5; Seattle North, June 6; Pasco/Kennewick, June 11; Yakima, June 12; Vancouver, June 18; Seattle South, June 20.

FEEDBACK FORM

As a tool to encourage input, a feedback form was developed and distributed at each Town Hall meeting. The form sought feedback pertaining to the four key provisions of the MSRW: co-payments, premiums, benefit design, and an enrollment freeze. For simplification, the form was a self-addressed prepaid folder that could be filled out, stapled, and mailed. DSHS received more than 100 forms with responses varying from nonsupportive to supportive.

MSRW WEB SITE

To provide additional information and to allow for another means by which interested parties could provide feedback, DSHS continued maintenance of the MSRW Web site at http://maa.dshs.wa.gov/medwaiver.

On the site, interested parties could review and download a four-page fact sheet that outlined the major elements of the MSRW, a PowerPoint presentation that was given at the ten Town Hall meetings, and Town Hall meeting notes from each Town Hall meeting. Additionally, interested parties were encouraged to read through the MSRW documents and send electronic comments via the Web site. DSHS received over 100 messages.

GOVERNMENT-TO-GOVERNMENT CONSULTATION

On May 2, 2002, an official notice was sent to the 29 tribes in the state of Washington requesting a Government-to-Government consultation to be held on June 4, 2002. The notice informed the

tribes of DSHS' intent to submit an amended MSRW and provided information on those elements of the MSRW that may impact the tribes and their members.

The meeting was attended by representation from ten tribes, the Governor's Health Policy Advisor, the Assistant Secretary of MAA, and other MAA staff. At the consultation, the tribes expressed a desire to review the completed draft MSRW and to meet again to discuss it. State staff agreed and will be meeting with the tribes on July 29 at the American Indian Health Commission meeting. MAA staff also made several presentations before DSHS' Indian Policy Advisory Committee on the MSRW's provisions and its potential impact on Washington's tribes.

HOW FEEDBACK FROM STAKHOLDERS WAS INCORPORATED

DSHS collected many suggestions and comments during the ten Town Hall meetings and via the MSRW Web site from the last week of April through the end of June.

Suggestions and comments were given consideration while writing the amended MSRW. Where appropriate, suggestions and comments were incorporated into the MSRW. However, most statements were of a general nature either in support of or against the major provisions of the MSRW - namely, co-payments, premiums, changes in benefits, and an enrollment freeze.

On July 22, the draft MSRW using the HIFA template was disseminated to stakeholders for review before formal submission to CMS.

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ATTACHMENT J
Enrollment/Expenditure Freeze

Washington State's MSRW demonstration project will implement an enrollment freeze for its demonstration populations when its Medical Assistance programs' caseload and expenditures exceed the level appropriated by the Washington State Legislature.

The demonstration population's eligibility categories that would be subject to an enrollment freeze are:

(a) Categorically Needy (CN) optional children (infants up to age one in households with incomes between 185 percent and 200 percent of the federal poverty level (FPL); children age one through five in households with incomes between 133 percent and 200 percent of FPL; and children age six through 18 in households with incomes between 100 percent and 200 percent of FPL);

(b) CN optional Healthcare for Workers with Disabilities;

(c) Medically Needy (MN) elderly persons age 65 and older who meet the state's Medically Needy Income Limits (MNIL) through medical spenddown;

(d) MN blind and disabled persons who meet federal blind and disability standards and who meet the state's MNIL through medical spenddown;

(e) MN pregnant women and children who meet the state's MNIL through medical spenddown; and,

(f) State Children's Health Insurance Program (SCHIP) children (children through age 18 in households with incomes between 200 percent and 250 percent of FPL).

The enrollment freeze would not apply to other Medicaid eligibility groups, including: all CN Mandatory eligibility groups (families with dependent children, Supplemental Security Income (SSI) beneficiaries age 65 and older, SSI beneficiaries who are blind or with disabilities, pregnant women with incomes up to 185 percent of FPL, and CN mandatory children); CN Optional elderly; CN Optional blind or disabled; or CN Optional women with breast or cervical cancer.

The enrollment freeze would apply to "new" persons seeking coverage in the demonstration population's eligibility groups. The freeze would not apply to persons with existing Medical Assistance coverage who are transferred to these eligibility categories due to a change in circumstances affecting their eligibility status.[1]

The Department of Social and Health Services (DSHS) will implement an enrollment freeze when the forecasted caseload and associated total expenditures for all of DSHS' medical programs are projected to exceed the level appropriated by the State Legislature for that state fiscal year (SFY). The mechanism to impose an enrollment freeze will be a caseload/expenditure "trigger."

Upon determining that the Medical Assistance programs' caseloads and expenditures are projected to exceed the appropriation's level, DSHS will notify the Office of Financial Management (OFM) and the Governor. The Governor will decide whether to implement the enrollment freeze.

Under the waiver, the Governor will be able to implement a freeze across all the eligibility groups covered under the demonstration population, or to implement the freeze on selective eligibility groups. DSHS and the Governor will inform the House and Senate fiscal and policy committees regarding the decision. DSHS also will notify the Centers for Medicare and Medicaid Services' (CMS) Central Office and Regional Office of both the caseload and expenditure projections and decision to implement the freeze.

Once a decision has been made to implement the freeze, DSHS' eligibility offices (DSHS' Economic Services Administration's (ESA) Community Services Offices (CSO), DSHS' Aging & Adult Services Administration's (AASA) Home and Community Services Offices (HCSO), and DSHS' Medical Assistance Administration's (MAA) Medical Eligibility Determination Services (MEDS)) will be notified of the effective date of the freeze. There also will be a public notice of the freeze.

Agency staff will be instructed to continue accepting applications and conducting eligibility determinations for all new applicants. For eligibility categories affected by the enrollment freeze, the completed applications will provide DSHS with an accurate count of the number of persons on the waiting list of coverage. The applicants' completed application dates will serve as the basis for priority ranking on the waiting list.

The enrollment freeze will be maintained until such time as the State Legislature appropriates necessary funding to lift the freeze or a sufficient number of persons have terminated from coverage so that the Medical Assistance's medical expenditures are below the appropriated level.

[1] On average, 70 percent of persons enrolled in eligibility categories are new (i.e., they were not in a coverage group during the prior month) and 30 percent are transferring from another eligibility category. The rate for CN non-grant children is 69 percent for new enrollees, while the rate for MN elderly and disabled is about 58 percent. Additional data are available upon request for SFY 2001 entry and exit rates by eligibility group.

An enrollment freeze would be in effect no more than six months before the Legislature would routinely convene for a session, and would be able to decide what action should be taken regarding the freeze.

Under the waiver, Washington's Legislature will be able to take one of four actions. It could direct DSHS to lift the freeze by enacting a supplemental budget that would provide funding for DSHS' Medical Assistance programs for the given year. Second, it could direct DSHS to retain the freeze for the remainder of the fiscal year, but enact a supplemental appropriation that would allow DSHS to lift the freeze at the beginning of the next fiscal year in the biennium.

Third, the Legislature could provide supplemental funding to lift the enrollment freeze on one or more of the optional eligibility groups under the demonstration population, but not all of the groups. For example, they could appropriate funding for the CN Optional children, but not the MN aged, blind or disabled.

Fourth, the Legislature could appropriate supplemental funding to finance the additional caseload and expenditure increases associated with the Medicaid CN Mandatory and CN Optional eligibility groups not affected by the enrollment freeze, but not provide supplemental funding for the optional eligibility groups in the waiver's demonstration population. DSHS could be instructed to implement a "managed enrollment" whereby enrollment in the demonstration population would be opened when there was a sufficient reduction in enrollment due to persons leaving these eligibility groups, resulting in a projected expenditure level below the appropriated level. DSHS would be able to enroll persons on the waiting list up to the level that could be financed with existing appropriations.

1. Caseload/Expenditure Trigger

Washington's Medicaid program allows providers up to 12-months to bill for rendered services. Although most providers bill electronically, there is a four- to six-month lag in obtaining complete and accurate month of service expenditure data. Caseload data are obtained more quickly. Given retroactive eligibility, accurate month-of-service caseload data are available within three months.

The Washington State Caseload Forecast Council (CFC) also provides revised caseload forecasts for a given state fiscal year (SFY) at the start (July) of that year and by the beginning of the second quarter (October) of that year. Given the more timely nature of the caseload data, DSHS will use actual and forecast caseloads as the "trigger" for implementing an enrollment freeze.[2]

DSHS' medical programs' caseloads are developed by the CFC. CFC forecasts caseload

[2] The Caseload Forecast Council is authorized by Chapter 43.88C RCW.

projections for each Medicaid and other DSHS medical programs' eligibility groups.[3] The forecasts are developed by CFC's technical workgroup comprised of CFC, Office of Financial Management (OFM), legislative fiscal and policy committee, DSHS Budget Division and DSHS Medical Assistance Administration staff.

CFC prepares caseload forecasts three times a year. The November CFC forecast is used by the Executive Branch to develop the Governor's biennial budget and supplemental budget requests. The February CFC forecast is used the following calendar year by the Legislature to make its biennial appropriations for state agencies, as well as supplemental appropriations to address expenditure shortfalls or other unanticipated changes. CFC then generates a June caseload forecast update for the coming fiscal year and biennium.

The decision to impose the enrollment freeze will be based on the revised CFC forecast plus actual caseload for all of the Medical Assistance programs for a given year compared to the caseloads used to develop the program's appropriation funding. The revised caseload for each forecasted eligibility group will be multiplied by the most current per-capita expenditure projections to estimate how much the total Medical Assistance program's expenditures are projected to exceed the expenditures assumed in the program's original appropriation for the state fiscal year.

2. Enrollment Freeze Example

Following is a narrative example of how Washington's enrollment freeze could be implemented. DSHS and OFM will prepare the Governor's 2003-05 Budget Request for the period July 1, 2003, through June 30, 2005. The Medical Assistance program's budget is based on CFC's November 2002 caseload forecasts for 16 Medical Assistance eligibility groups. The caseload forecast uses actual data through April 2002. The forecasts cover the period from January 2001 through June 2005. The expenditure and per-capita data are for the same period.

The 2003 Legislature will prepare and enact a 2003-2005 appropriation that authorizes Medical Assistance programs for the July 1, 2003, through June 30, 2005, period. The appropriation is based on the February 2003 forecast, which updates the November 2002 forecasts using actual data through October 2002. The February 2003 updated forecast will provide the caseload and detailed per-capita expenditures for the Medical Assistance's 16 eligibility categories upon which the program's two-year operating budget is predicated.

In June 2003, CFC will issue an updated caseload forecast for the July 1, 2003, through June 30, 2005, period. This forecast will use actual data through February 2003.

[3] CFC currently develops two and four year projections for 16 separate eligibility groups (CN TANF, CN Aged, CN Blind/Disabled, CN Pregnant Women, CN Non-Grant Children, CN Women with Breast & Cervical Cancer, CN Medicaid Buy-In, MN Aged, MN Blind/Disabled, MN Other, MCS GAU, MCS ADATSA, Medically Indigent, Refugee Assistance, QMB, and SCHIP).

The June forecast will provide DSHS with an assessment of how well the SFY 2004 and 2005 appropriation's level forecast is tracking with more current data. The forecast will provide a first review and decision point on whether there is a need to implement an enrollment freeze at the start of SFY 2004. If there is a significant difference between the two caseload projections that results in a difference in anticipated expenditures for SFY 2004, DSHS and the Governor could elect to implement an enrollment freeze at the start of the fiscal year. The freeze could be imposed on one or all of the demonstration population's CN and MN optional eligibility groups.

The second point of review would be in October 2003, when the CFC's technical workgroup completes its November 2003 forecast and DSHS revises its per-capita expenditure projections for the Governor's 2004 Supplemental Budget Request. If there is a significant difference between the February 2003 and November 2003 caseload projections and associated per-capita costs that results in a difference in anticipated expenditures for SFY 2004, DSHS and the Governor could elect to implement an enrollment freeze in November or December. The freeze could be imposed on one or all of the demonstration population's CN and MN optional eligibility groups.

In the examples outlined above, an enrollment freeze would be in place not more than six months before the State Legislature convened its next regular session to take action on how to proceed with the enrollment freeze.

The State Legislature would be able to take one of the several actions outlined above, which includes: (a) enact a supplemental budget to lift the freeze for one or more of the demonstration population's eligibility groups; (b) direct DSHS to retain the freeze for the remainder of the fiscal year, but enact a supplemental appropriation that would allow DSHS to lift the freeze at the beginning of the next fiscal year in the biennium; or (c) appropriate supplemental funding to finance the additional caseload and expenditure increases associated with the Medicaid CN Mandatory and CN Optional eligibility groups not affected by the enrollment freeze, but not provide supplemental funding for the optional eligibility groups in the waiver's demonstration population. DSHS would be instructed to implement a "managed enrollment" whereby enrollment in the demonstration population would be opened when there was a sufficient reduction in enrollment due to persons leaving these eligibility groups, resulting in a projected expenditure level below the appropriated level.